



Date: _____

Patient Name: _____ Preferred: _____
Last First MI

() Married () Single () Child

Social Security Number: _____ Birth Date: _____

Drivers License Number: _____ State: _____ Email Address: _____

Phone Number: (Home) _____ (Work) _____ (Cell) _____

Address: _____
Street Apt.

City: _____ State: _____ Zip: _____

Referred By: _____

In Case of an Emergency: _____ Phone: _____
First Last

Date of last visit: _____ Reason for this visit: _____

Have you ever had the following? Please check those that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Birth Control (currently) | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | Explain: _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | _____ | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Hepatitis | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Jaundice | _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Liver Disease | _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Mental Disorders | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervous Disorders | _____ |
| <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Breast feeding (currently) | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pregnant (currently) | _____ |
| <input type="checkbox"/> Epilepsy | Due Date: _____ | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Growths | <input type="checkbox"/> Rheumatic Fever | |
| | <input type="checkbox"/> Rheumatism | |

ALLERGIES - Do you have allergies to the following? :

Penicillin Aspirin Metals Tetracycline Latex Codeine Acetaminophen
 Other (not listed): _____

MEDICATIONS – Please list all prescription, medications, and any other medicines/dietary supplements taken on a regular basis: _____

Have you been told that you need to take antibiotics before EVERY dental appointment?

Yes, please explain: _____
 No

Have you been admitted to the hospital, or needed EMERGENCY care during the past two years?

Yes, please explain: _____
 No

Are you currently under the care of physician?

Yes, please explain: _____
 No

Regular physician/medical provider's name: _____ Phone: _____

Any health issues not listed above?

Yes, please explain: _____
 No

Patients in this clinic understand that cancellation of an appointment with less than 24 hours notice may be subject to a Failed Appointment charge.

To the best of my knowledge, all preceding information provided is true and correct.
I will inform the clinic staff immediately of any change in my health.

Date: _____

Signature of patient/guardian

Employer name: _____ Occupation: _____

Employer's Address: _____ Phone: _____

Responsible Billing Party's or Insured Person's Name: _____

Patients relationship to responsible billing party or insured: () Self () Spouse () Child () Other (specify)

Primary Dental Insurance Plan (Name and Address): _____

Insured Birth Date: _____ SS#: _____ Plan ID#: _____ Group #: _____

Insured's Address: _____
Street City State Zip

Insured's employers Name, Address, and Phone: _____

If you have secondary dental insurance, please provide same information for that as for primary insurance:

Consent for Services

I hereby grant permission for the diagnosed conditions to be treated as recommended. I have been advised of the reasons for such treatment, and of other treatment options, if any. I understand there are risks involved with treatment for health conditions, and although successful treatment results will be strived for, favorable outcomes cannot be guaranteed.

If I am covered by dental insurance, all services furnished are charged directly to me, and I am personally responsible for payment of all services, whether such services are covered by insurance or not. Any payments received from insurance companies will be applied to my account.

I hereby grant authorization for payment of insurance benefits directly to Midlakes Dentistry, LLC/ Dr. Gregory D. Tuttle. This includes release of all information necessary to secure payment of benefits. The information I have given is true and correct. I agree that a photocopy of this agreement is valid as the original.

Date: _____

Signature of patient/ guardian