Brent W. Dunavin, D.D.S.

Section 1: PATIENT INFORMATION

Date: _____ / _____ / _____

Name: ____
LAST FIRST MI

BIRTHDATE _____ / _____ / _____ AGE: _______

Marital Status: S M W D Sep

Social Security # ________ - ______ - ________

Home Address: ____

____
CITY STATE ZIP

Mailing Address: ____

____
CITY STATE ZIP

Home # (________) ________ - ________

Work # (________) ________ - ________

Cell # (________) ________ - ________

Employer: ____

____

Employer's Address: ____

____

How long there? ________ Title: ________________

Where and best times to reach you? ________________

____

Who may we thank for referring you? ________________

____

Previous / Present Dentist: ________________________

Date of Last Visit: ________________________

Person to notify in case of emergency: ________________

____

Section 2: SPOUSE INFORMATION

Name: ____

BIRTHDATE _____ / _____ / _____

Social Security # ________ - ______ - ________

Employer: ____

Work # (________) ________ - ________

Cell # (________) ________ - ________

Person responsible for account: ________________________

____

Billing Address: ____

____

____

Relationship to Patient: ________________________

Section 3: INSURANCE COVERAGE

Primary Dental Insurance

Company Name: ________________________

Address: ________________________

____

Phone # (________) ________ - ________

Group Policy #: ________________________

Insured's Name: ________________________

Relationship to Patient: ________________________

Insured's Birthdate: ________________________

Insured's SS# ________ - ______ - ________

Insured's Employer: ________________________

Secondary Dental Insurance

Company Name: ________________________

Address: ________________________

____

Phone # (________) ________ - ________

Group Policy #: ________________________

Insured's Name: ________________________

Relationship to Patient: ________________________

Insured's Birthdate: ________________________

Insured's SS# ________ - ______ - ________

Insured's Employer: ________________________

Section 4: OTHER PAYMENT

I recognize that I am ultimately responsible for all fees related to my treatment. For that portion not covered by insurance, I will pay by:

❑ Cash or Check ❑ Bank card (Visa / Mastercard / Discover)

All professional services rendered are charged to the patient. Insurance claims are filed as a courtesy to our patients. However, the patient is responsible for all fees, regardless of insurance coverage. We request payment for services when rendered unless other arrangements have been made in advance with our accounts manager.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Dr. Dunavin to furnish information to my insurance carrier(s) concerning my dental treatment and I hereby assign to the dentist(s) all payments for services rendered to myself or my dependents. In understand that I am responsible for any amount not covered by insurance.

DATE: ________________ **SIGNATURE:** ____

Brent W. Dunavin, D.D.S.

HEALTH INFORMATION Date: _____ / _____ / _____

Name: ____ ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Miss
LAST FIRST MI

❑ Male ❑ Female Birthdate ________ / ________ / ________ Age: ____________________

Do you have a personal physician? ❑ **No** ❑ **Yes**

Physician's Name: ______________________________

Phone # ________________ Date of last visit: ____________

Your current physical health is:
❑ **Good** ❑ **Fair** ❑ **Poor**

Are you currently under the care of a physician?
❑ **Yes** ❑ **No** **Please explain:** ____________
____

Have you ever had any of the following diseases or medical problems?
Y = Yes N = No

Y N Mitral Valve Prolapse
Y N Artificial Bones/Joints
Y N Artificial Heart Valves
Y N Heart Murmur
Y N Congenital Heart Defect
Y N Rheumatic Fever
Y N Heart Surgery/Pacemaker
Y N Blood Transfusion
Y N Hepatitis
Y N HIV /AIDS
Y N Drug/Alcohol Abuse
Y N Shingles
Y N Cancer/Chemotherapy
Y N Sinus Problems
Y N Difficulty Breathing
Y N Anemia/Radiation Treatment
Y N Psychiatric Problems
Y N Epilepsy/Seizures
Y N Kidney Problems
Y N Diabetes
Y N High/Low Blood Pressure
Y N Fever Blisters
Y N Severe/Frequent Headaches
Y N Ulcers/Colitis
Y N Emphysema/Glaucoma
Y N Venereal Disease
Y N Abnormal Bleeding
Y N Hemophilia
Y N Heart Attack/Stroke
Y N Asthma/Arthritis
Y N Hospitalized for Any Reason: ____________

Are you taking any prescription/over-the-counter drugs? ❑ **Yes** ❑ **No**
Please list each one: ____________________
____

Why have you come to the dentist today? ___
____

Are you currently in pain? ❑ Yes ❑ No
Have you ever had a serious/difficult problem associated with any previous dental work?
❑ Yes ❑ No Specify: ______________
Do you now or have you ever experienced pain/discomfort in your jaw joint? ❑ Yes ❑ No
Your current dental health is:
❑ Good ❑ Fair ❑ Poor
Do you like your smile? ❑
Do your gums bleed? ❑
How many times/week do you brush? ________
floss? ________
Type of bristles? ❑ Hard ❑ Medium ❑ Soft

Please specify any serious medical conditions you have ever had:
____

Are you allergic to any of the following:
Y N Penicillin
Y N Erythromycin
Y N Sulfa
Y N Tetracyclines
Y N Dental Anesthetics
Y N Aspirin
Y N Latex
Y N Codeine

Please specify any other drugs you have reacted to in the past:
____

FOR WOMEN
Are you taking birth control pills? ❑ No ❑ Yes
Are you pregnant? ❑ No ❑ Yes Week # _____
Are you nursing? ❑ No ❑ Yes

Does dental treatment make you nervous?
❑ No ❑ Slightly
❑ Moderately ❑ Extremely

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to preform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

____
Signature