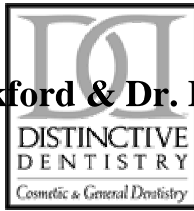

Dr. Jack Bickford & Dr. Bobby Shirley

Patient

First Name ________________________ Last Name __________________________ Middle Initial _____

Preferred Name __________________

Address ____ City, State, Zip ____________________________

Home Phone _______________ Work Phone ________________ Ext _______ Cell ___________________

Email ____

Sex ____Male ____ Female Marital Status: ___Married ___Single ___Divorced ___Separated ___Widowed

Birth Date ___________ Social Security _____________ Drivers Lic_______________

Employer Name ________________________________ Phone # _______________________

Address ____ City, State, Zip ____________________________

Responsible Party (if different from above)

First Name _________________________ Last Name _________________________ Middle Initial _____

Address ____ City, State, Zip ____________________________

Home Phone _______________ Work Phone ________________ Ext _______ Cell ___________________

Email ____ Sex ____Male ____ Female

Birth Date ___________ Social Security _____________ Drivers Lic_______________

Is responsible party also Insurance policy holder? _____Yes ______ No

---

Insurance Information

Insurance Company _____________________________ Phone # _______________________

Address ____ City, State, Zip ____________________________

Subscriber ID __________________________ Group #________________________

Name of Insured ________________________________ Relationship to Patient ___Self ___Spouse ___Parent

Insured Soc. Sec. _________________ Insured Birth Date ____________ Home Phone ________________

Address ____ City, State, Zip ____________________________

Employer Name ________________________________ Phone # _______________________

Address ____ City, State, Zip ____________________________

List all family members and date of birth under this group:

____

____

____

How did you hear about our office? _______________________________________

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ___ Yes ___ No If yes, please explain: ___________________________

Have you been hospitalized or had a major operation? ___ Yes ___ No If yes, please explain: ___________________________

Have you ever had a serious head or neck injury? ___ Yes ___ No If yes, please explain: ___________________________

Are you taking any medications, pills, or drugs? ___ Yes ___ No If yes, please explain: ___________________________

Do you take, or have you taken, Phen-Fen or Redux? ___ Yes ___ No If yes, please explain: ___________________________

Are you on a special diet? ___ Yes ___ No If yes, please explain: ___________________________

Do you use tobacco? ___ Yes ___ No

Do you use controlled substances? ___ Yes ___ No

Women: Are you

___ Pregnant/Trying to get pregnant? ___ Nursing?

____Taking Oral Contraceptives?

Are you allergic to any of the following?

___ Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___ Metal ___ Latex ___ Local Anesthetics

___ Other If yes, please explain: ____

Do you have, or have you had, any of the following?

___ AIDS/HIV Positive	___ Chest Pains	___ Frequent Headaches	___ Irregular Heartbeat	___ Scarlet Fever
___Alzheimer's Disease	___ Cold Sores/Fever Blisters	___ Genital Herpes	___ Kidney Problems	___ Shingles
___ Anaphylaxis	___ Congenital Heart Disorder	___Glaucoma	___ Leukemia	___ Sickle Cell Disease
___ Anemia	___ Convulsions	___ Hay Fever	___ Liver Disease	___ Sinus Trouble
___ Angina	___ Cortisone Medicine	___ Heart Attack/Failure	___ Low Blood Pressure	___Spina Bifida
___ Arthritis/Gout	___ Diabetes	___ Heart Murmur	___ Lung Disease	___Stomach/Intestinal Disease
___ Artificial Heart Valve	___ Drug Addiction	___ Heart Pace Maker	___ Mitral Valve Prolapse	___ Stroke
___ Artificial Joint	___ Easily Winded	___ Heart Trouble/Disease	___ Pain in Jaw Joints	___ Swelling of Limbs
___ Asthma	___ Emphysema	___ Hemophilia	___ Parathyroid Disease	___ Thyroid Disease
___ Blood Disease	___ Epilepsy or Seizures	___ Hepatitis A	___ Psychiatric Care	___ Tonsillitis
___ Blood Transfusion	___ Excessive Bleeding	___ Hepatitis B or C	___ Radiation Treatments	___ Tuberculosis
___Breathing Problem	___ Excessive Thirst	___ Herpes	___ Recent Weight Loss	___ Tumors or Growths
___ Bruise Easily	___ Fainting Spells/Dizziness	___ High Blood Pressure	___ Renal Dialysis	___ Ulcers
___ Cancer	___ Frequent Cough	___ Hives or Rash	___ Rheumatic Fever	___ Venereal Disease
___ Chemotherapy	___ Frequent Diarrhea	___ Hypoglycemia	___ Rheumatism	___ Yellow Jaundice

Have you ever had any serious illness not listed above? ___ Yes ___ No If yes, Please explain _______________________________

Comments: ____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Questionnaire

Patient Name:______________________________

Date:____________

This questionnaire is designed to help you begin to explore the priorities you'd like me to consider during your first visit. Please mail this back with the rest of your information.

1. What are the main concerns about your mouth that you would like for me to address at your first visit?

2. Is there anything I should know about any past Dental treatment or Dental experiences you have had?

3. Is there anything else that you want to tell me about yourself that will help me Treat you most effectively?

4. Do you feel more comfortable with information that is provided verbally or in written form?