Welcome

Homer Dental Clinic, LLC
W. Jay Marley, Jr., D.D.S.
John H Anderson, D.D.S.
FAMILY DENTISTRY

PATIENT INFORMATION:

Today's Date: _____/_____/_____

Patient Name: _____
First Middle Last

Birthdate: _____/_____/_____ SS# _____-_____-_____

Mailing Address _____

_____
City State Zip

Physical Address _____

_____
City State Zip

Home Phone _____ Work_____

Cell_____

e-mail_____

Patient's Occupation _____

Employer _____

Employer's Address _____

How did you hear about us?_____

Marital Status: S___ M___ D___ W___

Spouse's Name: _____
First Middle Last

Spouse's Birthdate: ____/____/_____

Spouse's Employer _____

Employer's Address _____

Employer's Phone _____

In Case of Emergency, Please Contact:

_____
Name

_____ _____
Relationship Phone Number

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

Who is the guarantor for this account?

_____
First Middle Last

Relationship to Patient _____

-

DENTAL INSURANCE

We will bill your primary insurance as a courtesy to you. However, we work for our patients and not the insurance companies. In the event of benefit denial or delay, ***you*** *as the patient* ***are ultimately responsible for your own account****.*

Insurance Co. Phone # _____

Group # _____

ID # _____

Are you covered by additional insurance? Yes___ No___

Subscriber's Name _____

Birthdate ____/___/____ ID# or SS# _____

Insurance Co. Phone # _____

Group # _____

ASSIGNMENT AND RELEASE

I authorize payment directly to Dr. Marley of insurance benefits otherwise payable to me. I authorize release of information relating to my dental claims. I understand I am ultimately responsible for all costs of dental treatment, whether or not covered by insurance, including a $10.00 monthly service fee on the unpaid balance and any fees incurred for collection of a delinquent account. I authorize the use of this signature on all insurance submissions.

GUARANTOR

SIGN_____

PRINT_____

»»OVER««

HEALTH HISTORY

Your complete and correct health information will assist us in providing you with safe, quality care. This office is HIPPA Compliant and respects your health information with the utmost of Privacy.

Physician's Name _____ Date of Last Visit _____

Do you use or have you ever used recreational or IV drugs? ☐ Yes ☐ No Type of Substance_____

Have you used any Steroid Medications in the last 6 months? ☐ Yes ☐ No

Have you *ever* taken medication (Fosamax or other) for Osteoporosis/Osteopenia? ☐ Yes ☐ No

Have you ever had Surgery? ☐ Yes ☐ No *If Yes, For What?*_____ *Date*_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes ☐ No		
Arthritis/Rheumatism	☐ Yes ☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes ☐ No		
Artificial Heart Valves	☐ Yes ☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes ☐ No		
Artificial Joints	☐ Yes ☐ No	Heart Problems or Defects	☐ Yes	☐ No	Skin Rash	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No	Heart Attack	☐ Yes	☐ No	Special Diet	☐ Yes ☐ No		
Back Problems	☐ Yes ☐ No	Hepatitis *Type* ☐A ☐B ☐C	☐ Yes	☐ No	Stroke	☐ Yes ☐ No		
Bleeding Abnormally	☐ Yes ☐ No	Herpes *Type* _____	☐ Yes	☐ No	Swelling of Feet or Ankles	☐ Yes ☐ No		
Blood Disease	☐ Yes ☐ No	High Blood Pressure Low Blood Pressure	☐ Yes Yes	☐ No ☐ No	Swollen Neck Glands	☐ Yes ☐ No		
Cancer *Type* _____	☐ Yes ☐ No	HIV / AIDS	☐ Yes	☐ No	Thyroid Problems	☐ Yes ☐ No		
Chemical / Alcohol Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes ☐ No		
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tumor or Growth on Head or Neck	☐ Yes ☐ No		
Cough- Persistent or Bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes ☐ No		
Diabetes *Type* ☐ I ☐ II	☐ Yes ☐ No	Psychiatric Care	☐ Yes	☐ No	Venereal Disease	☐ Yes ☐ No		
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes	☐ No	Weight Loss- Unexplained	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes	☐ No	***Women:*** Are You Pregnant? Due Date _____	☐ Yes ☐ No		
Fainting or Dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes	☐ No	Are You Nursing?	☐ Yes ☐ No		

MEDICATIONS

List all medications including alternative medications you are taking

_____

_____

_____

_____

Pharmacy Name_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (sleeping pills) ☐ Epinephrine Sensitivity

☐ Codeine ☐ Penicillin

☐ Iodine ☐ Sulfa

☐ Latex ☐ Other _____

DENTAL HISTORY

Reason for Today's Visit _____	Tobacco use	☐ Yes ☐ No	Grinding Teeth	☐ Yes ☐ No	
Date of Last Dental Visit _____	Alcohol use	☐ Yes ☐ No	Bad Breath	☐ Yes ☐ No	
Last Cleaning _____	TM Joint Problems	☐ Yes ☐ No	Sores in Mouth	☐ Yes ☐ No	
Last X-Rays _____	Sensitivity when Biting	☐ Yes ☐ No	Orthodontic Treatment	☐ Yes ☐ No	
Former Dentist _____	Gums Tender / Bleeding	☐ Yes ☐ No	Periodontal Treatment	☐ Yes ☐ No	
How often do you brush?	Anxiety with Dental Appointments?	☐ Yes ☐ No	Sensitivity to Hot/Cold	☐ Yes ☐ No	
How often do you floss? _____					

Are your happy with the appearance of your teeth?
☐ Yes ☐ Sort-of ☐ No ☐ Don't Care

Is there anything you would like to change about your teeth?

I attest that the information that I have given is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status.

Signature _____ **Date** _____