

TRUSTED DENTISTRY.

Dr. Guy J. Moore & Associates

Although dental practitioners primarily treat the area in and around your mouth, your mouth is an integral part of your overall health. Health problems you may have, or medication you may be taking, could have an important interrelationship with the dentistry you receive. Please answer the following questions:

AIDS/HIV Positive	Y	N
Alzheimer's Disease	Y	N
Anaphylaxis	Y	N
Anemia	Y	N
Angina/Chest Pains	Y	N
Arthritis/Gout	Y	N
Artificial Heart Valve	Y	N
Artificial Joint	Y	N
Asthma	Y	N
Blood Disease	Y	N
Blood Transfusion	Y	N
Bruise Easily	Y	N
Cancer (or history of)	Y	N
Cold Sores/Fever Blisters	Y	N
Congenital Heart Disorder	Y	N
COPD or Emphysema	Y	N
Diabetes	Y	N
Drug Addiction	Y	N
Epilepsy/Seizures/Convulsions	Y	N
Excessive Bleeding	Y	N
Fainting Spells/Dizziness	Y	N
Frequent Headaches	Y	N
Glaucoma	Y	N
Heart Disease/Heart Attack	Y	N
Hemophilia	Y	N
Hepatitis A, B or C	Y	N
Herpes	Y	N
High Blood Pressure	Y	N
Hives, Rash or Allergies	Y	N
Hypoglycemia	Y	N
Heart Murmur/Irregular Heart	Y	N
Kidney Problems/Dialysis	Y	N
Leukemia	Y	N
Liver Disease	Y	N
Low Blood Pressure	Y	N
Lung Disease/Breathing Problems	Y	N
Pain in Jaw	Y	N
Parathyroid Disease	Y	N
Psychiatric Care	Y	N
Radiation/Chemotherapy	Y	N
Restless Leg Syndrome	Y	N
Rheumatic Fever	Y	N
Shingles	Y	N
Sinus Trouble	Y	N
Stomach Disease	Y	N
Stroke	Y	N
Sleep Apnea	Y	N
Tuberculosis	Y	N
Ulcers	Y	N
Venereal Disease	Y	N

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- | | | |
|-------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Acrylic | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Metal | |

PLEASE ANSWER QUESTIONS BELOW

Pregnant or Trying to get Pregnant..... YES NO

Breastfeeding?..... YES NO

Are you under Physician's Care now?..... YES NO

Name and Number _____

Have you been hospitalized or had a major operation..... YES NO

Please Explain _____

Have you had a serious head or neck injury?..... YES NO

Please Explain _____

Do you use Tobacco/or have a history of using? YES NO

Do you use a controlled substance?..... YES NO

Do you pre-medicate prior to dental treatment?..... YES NO

Please List Medications _____

Are you taking any medication, pills or drugs?..... YES NO

Please List Medications _____

Have you ever had any serious illness not listed?..... YES NO

Please List _____

Additional Information _____

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.

_____/_____/_____
Signature of Patient, Parent or Guardian Date

MEDICAL HISTORY MUST BE UPDATED AT EVERY VISIT WITH STAFF INITIAL.

UPDATED: ____/____/____ INITIALS _____ UPDATED: ____/____/____ INITIALS _____ UPDATED: ____/____/____ INITIALS _____

PATIENT INFORMATION

Patient ID: _____

Name			Email		
Last	First	Middle			
Address					SSN
Street	City	State	Zip	-	-
Birthdate	Drivers License Number		Employer		
Home Phone	Cell Phone		Work Phone		

INSURANCE

Dental Insurance? YES or NO		Primary Insurance Cardholder's Name			
Birthdate	SSN	Employer			

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE)

Name			Relationship		
Last	First	Middle			
Address					SSN
Street	City	State	Zip	-	-
Home Phone	Cell Phone		Work Phone		
Birthdate	Employer				
Spouse's Name		Spouse's Employer		Work Phone	

EMERGENCY CONTACT INFORMATION (LOCAL FRIEND OR RELATIVE NOT LIVING WITH YOU)

Name			Relationship		
Address					Primary Phone
Street	City	State	Zip		

HOW DID YOU HEAR ABOUT US

THANK YOU FOR TRUSTING US WITH YOUR CARE. PLEASE TELL US HOW YOU CHOSE US .

<input type="checkbox"/> TrustedDentistry.com	<input type="checkbox"/> Online Ads	<input type="checkbox"/> NBC 33 (WNDU) TV	<input type="checkbox"/> Drive By
<input type="checkbox"/> Social Media	<input type="checkbox"/> Billboards	<input type="checkbox"/> CBS (WSBT) TV	<input type="checkbox"/> Walk In
<input type="checkbox"/> Phonebook	<input type="checkbox"/> U93 Radio	<input type="checkbox"/> Online Streaming	<input type="checkbox"/> Referral _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Willie / News Now	<input type="checkbox"/> Chamber of Commerce	(REFER A FRIEND AND RECIEVE \$25)

FOR ALL PATIENTS • NOTIFY OF PRIVACY PRACTICES DISCLOSURE OF INFORMATION

I have received the Notice of Privacy Practices from this office. I authorize Angola Dental Center and/or Aegis Dental Group to disclose information regarding my appointments, accounts, and any other protected health information directly to me via voicemail, electronic mail or text messaging using the contact numbers and addresses I have provided. I understand that my information is protected and will not be disclosed to any other parties unless specifically requested by me.

Signature of Patient _____

Date ____ / ____ / ____

FOR ALL PATIENTS

I authorize the doctor(s) to perform any and all forms of procedures, treatment, therapy, and medication that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor(s) chooses and employs such assistant(s) as he/she deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor(s) and/or his/her staff. I understand that I am responsible for payment of all services rendered.

Signature of Responsible Party _____ Relationship _____

Date ____ / ____ / ____