Shurett Dental Group

ADULT FORM

(Print Please)

PATIENT INFORMATION					
Name:				Date:	
Address:				Email Address:	
City:	State:	Zip Code:		Driver's License #:	
Date of Birth:	Age:	Social Security #:		☐ Male	☐ Female
Home Phone #:	Work Phone #:			Cell Phone #:	
Employer:				How Long There?	
Spouse's Name:		Social Security #:		Phone #:	
Spouse's Employer:				How Long There?	
Who may we thank for referring you to our office?					
Emergency Contact:		Phone #:		Relationship:	
Name of nearest relative not living with you:		Phone #:		Relationship:	

DENTAL HISTORY			
Why have you come to the dentist today?			
How often do you brush?		How often do you floss?	
Do your gums ever bleed?		Type of bristles on toothbrush? ☐ Hard ☐ Med ☐ Soft	
Previous Dentist:		Date of last visit:	
What have you liked most about any dentist?			
What have you liked least about any dentist?			
Are you more concerned with:	☐ Quick appointments	☐ Someone taking time to explain each procedure to you.	
In what ways would you like to improve your smile, if any?			
☐ Available on short notice? (Are you available on short notice in case we have a cancellation?)			

MEDICAL HISTORY					
Are you currently in the care of a physician?	☐ Yes	☐ No	Physician's Name:		
Last visit:			Phone Number:		
Do you smoke?	☐ Yes	☐ No	Do you use smokeless tobacco?	☐ Yes	☐ No
List any medications you are taking at the present time:					
List any allergies:					

WOMEN: Are you								
Pregnant?	☐ Yes	☐ No	Taking oral contraceptives?	☐ Yes	☐ No	Nursing?	☐ Yes	☐ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?						
☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Metal	☐ Latex	☐ Local Anesthetics
☐ Other	If yes, please explain:					

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DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?												
AIDS/HIV Positive	☐Yes	☐No	Cortisone Medicine	☐Yes	☐No	Hemophilia	☐Yes	☐No	Renal Dialysis	☐Yes	☐No	
Alzheimer's Disease	☐Yes	☐No	Diabetes	☐Yes	☐No	Hepatitis A	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No	
Anaphylaxis	☐Yes	☐No	Drug Addiction	☐Yes	☐No	Hepatitis B or C	☐Yes	☐No	Rheumatism	☐Yes	☐No	
Anemia	☐Yes	☐No	Easily Winded	☐Yes	☐No	Herpes	☐Yes	☐No	Scarlet Fever	☐Yes	☐No	
Angina	☐Yes	☐No	Emphysema	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Shingles	☐Yes	☐No	
Arthritis/Gout	☐Yes	☐No	Epilepsy or Seizures	☐Yes	☐No	Hives or Rash	☐Yes	☐No	Sickle Cell Disease	☐Yes	☐No	
Artificial Heart Valve	☐Yes	☐No	Excessive Bleeding	☐Yes	☐No	Hypoglycemia	☐Yes	☐No	Sinus Trouble	☐Yes	☐No	
Artificial Joint	☐Yes	☐No	Excessive Thirst	☐Yes	☐No	Irregular Heartbeat	☐Yes	☐No	Spina Bifida	☐Yes	☐No	
Asthma	☐Yes	☐No	Fainting Spells/Dizziness	☐Yes	☐No	Kidney Problems	☐Yes	☐No	Stomach/Intestinal Disease	☐Yes	☐No	
Blood Disease	☐Yes	☐No	Frequent Cough	☐Yes	☐No	Leukemia	☐Yes	☐No	Stroke	☐Yes	☐No	
Blood Transfusion	☐Yes	☐No	Frequent Diarrhea	☐Yes	☐No	Liver Disease	☐Yes	☐No	Swelling of Limbs	☐Yes	☐No	
Breathing Problem	☐Yes	☐No	Frequent Headaches	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Thyroid Disease	☐Yes	☐No	
Bruise Easily	☐Yes	☐No	Genital Herpes	☐Yes	☐No	Lung Disease	☐Yes	☐No	Tonsillitis	☐Yes	☐No	
Cancer	☐Yes	☐No	Glaucoma	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	Tuberculosis	☐Yes	☐No	
Chemotherapy	☐Yes	☐No	Hay Fever	☐Yes	☐No	Pain in Jaw Joints	☐Yes	☐No	Tumors or Growths	☐Yes	☐No	
Chest Pains	☐Yes	☐No	Heart Attack/Failure	☐Yes	☐No	Parathyroid Disease	☐Yes	☐No	Ulcers	☐Yes	☐No	
Cold Sores/Fever Blister	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	Venereal Disease	☐Yes	☐No	
Congenital Heart Disorder	☐Yes	☐No	Heart Pace Maker	☐Yes	☐No	Radiation Treatments	☐Yes	☐No	Yellow Jaundice	☐Yes	☐No	
Convulsions	☐Yes	☐No	Heart Trouble/Disease	☐Yes	☐No	Recent Weight Loss	☐Yes	☐No				

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain:

DENTAL INSURANCE INFORMATION			
Primary Insurance Company:			Phone #:
Address:			Group #:
City:	State:	Zip Code:	Birth Date
Insured's Name:			
Insured's Employer:			Social Security #

Secondary Insurance Company:			Phone #:
Address:			Group #:
City:	State:	Zip Code:	Birth Date
Insured's Name:			
Insured's Employer:			Social Security #

Agreement and Authorization

I understand that keeping appointments is very important. If I cannot make an appointment, for any reason, I must give at least 24 hours' notice. Failure to provide 24 hours' notice for a missed appointment may prevent me from being able to reserve future appointments in advance.

I understand that my health insurance carrier may pay less than the actual bill for services rendered on my behalf and my dependents, and that I am responsible for the difference. If I do not pay my entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in Shurett Dental Group being unable to provide additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees (usually 40% of the amount owed) incurred in attempting to collect on this account balance.

I certify that that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I give Shurett Dental Group permission to perform dental treatments on me/my child, which may include anesthesia for the patient's comfort. I authorize Shurett Dental Group to leave messages on my home answering machine or cell phone voice mail concerning appointment times, scheduled treatment including premedication reminders, and payment information.

I authorize Shurett Dental Group to use or disclose any necessary patient health information (PHI) in order to carry out treatment, payment activities, and healthcare operations, as fully described in our Notice of Privacy Practices. I understand that upon request I will receive a copy of the Notice of Privacy Policies as prescribed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Signature of Patient (or parent if a minor) Today's Date