Jared W. Stubbs DDS & Lisa A. Daft DMD, PC

Name:______________________________DOB____________M _____F___

Address:____________________City________________State________Zip____________

Phone: Home____________________Cell________________Work________________

Employer______________________________Marital status________________

Which phone number would you like to be confirmed at?______________________________

Would you like to be confirmed by e-mail? E-mail address______________________________

Person responsible for account (if not patient)________________Phone________________

Who can we thank for referring you to our office?______________________________

Medical History

Physician's name:________________Phone____________Date of last physical________

Have you been hospitalized in the last two years? Y / N If yes please explain______________________________

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Have you had any surgical procedures? Y / N If yes, when____________Why____________

Are you pregnant? Y / N Do you smoke? Y / N packs per day________ Are you prone to cold sores Y / N

Have you ever been treated for:

Heart disease	Y / N	Tuberculosis	Y / N	Blood Disorder	Y / N	Epilepsy	Y / N
Heart attack	Y / N	Alzheimer's	Y / N	Jaundice	Y / N	Anemia	Y / N
Heart Murmur	Y / N	Asthma	Y / N	Ulcers	Y / N	Stroke	Y / N
Pacemaker	Y / N	Rheumatic Fever	Y / N	Glaucoma	Y / N	Hepatitis	Y / N
Diabetes	Y / N	High Blood Pressure	Y/ N	Cancer	Y / N	Arthritis	Y / N
Aids/HIV	Y / N	Low Blood Pressure	Y / N	Kidney disorder	Y / N	Fainting	Y / N
Sinus Trouble	Y / N	Artificial joints/valves	Y / N	Multiple Sclerosis	Y / N	Dialysis	Y / N
Anxiety	Y / N	Congenital Heart Disease	Y / N	Blood Transfusion	Y / N	Headaches	Y / N
Radiation Treatment	Y/ N	Excessive use of soda, candy, gum	Y/ N	Lupus	Y / N		

Any special needs or concerns that will help make your visit most comfortable? ________________

Are you allergic to: **Penicillin** **Codeine** **Latex** **Local anesthetics** Other______________________________

Do you take: **Fosamax** **Actonel** **Boniva** (for Osteoporosis)

Have you received IV **Aredia** or **Zometa** for the treatment of cancer? Y / N

Current Medications	**Purpose**
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

As a courtesy to you, our office staff will submit claim forms to your insurance company. However, you are financially responsible for any costs you or your dependents may incur for non- covered services, deductibles, coinsurance amounts or amounts that exceed you annual maximum allowance. Finance charges of 1.5% monthly(18%annually) automatically begin to accrue on account balances over 90 days. I hereby authorize the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. I also authorize doctor to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon. I further authorize the release of any information, including, the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled.

Signature of patient or responsible party______________________________**Date**__________