SCOTT M. HEALEY D.M.D., P.C.
530 N. State Lindon, UT 84062
785-0584

CONFIDENTIAL PATIENT INFORMATION

Name: ______________________ Address: ______________________ City: ______________
State:______ Zip Code: ____________ Telephone: Home______________ Cell______________
SS#:__________________ Birthdate: ______________ Age:__________ Sex: M or F
Occupation: ______________Employer:______________________ Address: ______________________
Work Phone#: ______________ Marital Status: (Circle one) Single, Married, Divorced, Widowed
Spouse Name: ______________________________
Previous Dentist: ______________________ How Long? ______________ Telephone: ______________

PERSON RESPOSIBLE FOR PATIENT (If a minor)

Name: ______________________ Address: ______________________ City: ______________
Zip Code: ______________Telephone: Home ______________ Cell ______________
Relationship: ______________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co: ______________________ Address: ______________________
Telephone: ______________Policy holder: ______________ Policy holders Birthday:__________ ID#: __________
Group# ______________Policy holder employer:______________________ Employer phone number:_______
Secondary Insurance Co: ______________________ Address: ______________________
Telephone: ______________Policy holder:______________ Policy holders Birthday:__________ ID# __________
Group# ______________Policy holders employer:______________________ Employers phone number:__________

HEALTH INFORMATION

Physician Name: ______________________ Address: ______________________ Telephone: ______________
YES NO 1. Have you been hospitalized within the past 2 years? Please describe? ______________________
YES NO 2. Are you currently being treated by a physician? Please describe? ______________________
YES NO 3. Are you currently taking any medicines or drugs? What? ______________________
YES NO 4. Have you had any reactions (rash, itching, etc.) to any medications or metals? What? ______________
YES NO 5. (Women) Are you pregnant? Month __________ Dr. ______________________
YES NO 6. Have you ever been involved with dental/medical legal activity?
YES NO 7. Do you bleed excessively upon injury?

CIRCLE ALL MEDICAL CONDITIONS THAT APPLY

A. Aids	H. Heart Murmur	O. Nervous Breakdown or Psychiatric Therapy
B. Arthritis	I. Heart Problem	P. Rheumatic Fever
C. Asthma	J. Hepatitis	Q. Sexually Transmitted Diseases
D. Cancer	K. High Blood Pressure	R. Stroke
E. Diabetes	L. Jaundice	S. Tuberculosis
F. Epilepsy	M. Kidney Problems	T. Other Diseases______________________
G. Glaucoma	N. Low Blood Pressure	

DENTAL HISTORY

Date of last dental exam or treatment ______________________
Have you noticed any of the following?
YES NO Teeth tender to chew on YES NO Bleeding gums Do you want to maintain your own teeth? Yes No
YES NO Bad breath YES NO Teeth sensitive to hot/cold Do you want to improve the appearance of your teeth? Yes No
YES NO Food catching between teeth YES NO Sore areas in your mouth Do you clench or grind your teeth? Yes No
Have you ever had a unfavorable reaction to dental treatment? Yes No

Referred By ____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY

Name: ______________________ Telephone: ______________Cell phone:______________________

AUTHORIZATION: I grant authority to the dentist to perform procedures and treatments, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary and do voluntarily assume any and all possible risks which may be associated with these treatment procedures. I agree to pay any interest on a delinquent account, collection costs, and/or a reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit. I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature: ______________________________________ Date: ______________