SCOTT M. HEALEY D.M.D., P.C – FAMILY DENTISTRY AND ORTHODONTICS

530 N. State Lindon, UT 84062 (801) 785-0584

CONFIDENTIAL PATIENT INFORMATION Date:_____

Name:_____ Preferred name:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ E-mail:_____

Date of Birth:_____ Age:_____ Sex:_____ Marital Status:_____ Social Security #:_____

Employer:_____ Work Address:_____ Employer Phone #:_____ Occupation:_____

Best place & time to contact you:_____ Appointment reminders preferred via: Text E-mail Mail

Please tell us where you heard about us:_____

Name of Spouse/Parent:_____ Spouse/Employer:_____ Spouse/Employer work/cell phone:_____

DENTAL INSURANCE INFORMATION

Primary Insurance Co:_____ Address:_____ Telephone:_____

Policy Holder:_____ Policy Holder's DOB (mm/dd/yyyy):_____ Member ID#:_____ Group #:_____

Policy Holder's Employer:_____ Employer's Phone #:_____

Secondary Insurance Co:_____ Address:_____ Telephone:_____

Policy Holder:_____ Policy Holder's DOB (mm/dd/yyyy):_____ Member ID#:_____ Group#:_____

Policy Holder's Employer:_____ Employer's Phone #:_____

EMERGENCY CONTACT (nearest relative who does not live with the patient)

Name:_____ Relationship:_____ Home Phone:_____ Work Phone:_____ Cell Phone:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____ Relationship:_____ Date of Birth:_____ Social Security #:_____ UDL#:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ E-mail:_____

Billing Address:_____ City:_____ State:_____ Zip Code:_____

Employer's Name:_____ Employer's Phone:_____ Employer's Address:_____

DENTAL HISTORY

Previous Dentist:_____ Address:_____ City:_____ State:____ Zip:_____

Describe any dental problems, pain, or discomfort:_____ Reason for visit:_____

Date of last dental exam or treatment:_____ Describe unfavorable reaction to dental treatment?_____

Have you noticed any of the following?

YES NO Do you clench or grind your teeth? YES NO Do you want to maintain your own teeth?

YES NO Are any teeth tender to chew on? YES NO Do you want to improve the appearance of your teeth?

YES NO Is food catching between teeth? YES NO Have you ever had an unfavorable reaction to dental treatment?

Circle all that apply:

Bad breath	Crooked	Grinding	Missing teeth	Sensitive to sweets
Bad taste	Dental phobias	Gums sore	Mouth sores	Sore areas
Bleeding gums	Difficulty chewing	Headaches	Orthodontic treatment	Snoring
Broken teeth	Discoloration	Loose filling	Popping/clicking in jaw	Tooth pain
Crooked	Food trap areas	Loose teeth	Sensitive to bite	Wisdom teeth

MEDICAL HISTORY

Physician Name:_____ Address:_____ Telephone:_____

YES NO Have you been hospitalized within the past 2 years? Please Describe:_____

YES NO Are you currently being treated by a physician? Please Describe:_____

YES NO Are you currently taking any medicines or drugs? Please Describe:_____

YES NO Have you had any reactions (rash, itching, etc.) to any medications or metals? What?_____

YES NO (Women) Are you pregnant? If so, what month?_____

Circle all that apply:

Aids	Epilepsy	High Blood Pressure	Rheumatic Fever
Arthritis	Glaucoma	Low Blood Pressure	Sexually Transmitted Diseases
Asthma	Heart Problem	Kidney Problems	Stroke
Cancer	Hepatitis	Nervous Breakdown	Tuberculosis
Diabetes	Jaundice	Psychiatric Therapy	Other:_____

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

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 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:_____