

Please print and complete the following information. It will remain confidential.

Date _____

Name _____

Spouse _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Email _____

Birthdate _____ Age _____

Male Female Married Single Divorced Widowed

Social Security No. _____

Person to Contact for Emergency _____

Phone Number _____

Address _____

City _____ State _____ Zip _____

Closet relative not living with you _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

▪ Child's Appointment ▪

Name _____

Birthdate _____ Age _____

Male Female

Social Security No. _____

If your child's last name and/or address are not the same as yours, please add this additional information:

Address _____

City _____ State _____ Zip _____

▪ Dental Insurance ▪

Primary Carrier _____

Insurance Company _____

Group No. _____

Employee Insurance

Date of Birth _____

Date Employed _____

Union or Local No. _____

Employee No. _____

Employee Social Security No. _____

Secondary Carrier

Insurance Company _____

Group No. _____

Employee _____

Date of Birth _____

Date Employed _____

Union or Local No. _____

Employee No. _____

Employee Social Security No. _____

▪ Person Financially Responsible for Account ▪

Name _____

I am responsible

Another person is responsible:

Name _____

Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

▪ Health History ▪

1. Are you having pain or discomfort at this time? Yes No
2. Have you been a patient in the hospital during the past two years? Yes No
3. Have you been under the care of a medical doctor during the past two years? Yes No

Physician's Name _____ Phone No. _____

Address _____

4. Have you taken any medication or drugs during the past two years? Yes No
5. Are you now taking any medication or drugs or pills? Yes No

If yes, please list _____

6. Are you aware of being allergic to
or have you ever reacted adversely to any medication or substance? Yes No

If yes, please list _____

7. Are you on a special diet? Yes No

8. Has your medical doctor ever said you have a cancer or tumor? Yes No

9. For women only
Are you pregnant? Yes No

Yes, what month? _____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

10. Indicate which of the following you have had or have at present. Mark yes or no for each item.

A.I.D.S	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies or Hives	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina Pectoris	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arteriosclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	H.I.V. Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints (hip, knee, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease or Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis A (infectious)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis B (serum)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Medicine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cosmetic Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Radiation Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sickle Cell Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No

11. Do you have or have you had any disease, condition or problem not listed above? Yes No

If yes, please list _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Consent

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and the use of appropriate medication and therapy indicated for such treatment in connection with (patient's name) _____ . I understand using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand all responsibility for payment for dental services provided in this office for myself or my dependents is mine. due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1 1/2% finance charge (18% APR) may be added to my account.

Patient: _____ Date: _____

Witness: _____

Parent or Responsible Party: _____

Relationship to Patient: _____

Please return form to Dr. Austin W. Holmes ▪ 1927 23rd Avenue ▪ Meridian, MS 39301
Email: drholmes@austinwholmesdmd.com