

Our goal is to provide our patients the most healthy, beautiful smiles they deserve.

Today's date: _____

ABOUT YOU

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Please check contact preference:

Home phone: _____ Work phone: _____

Cell phone: _____ Texts: E-mail: _____

Date of birth: _____ SSN: _____

Name of spouse: _____

Name(s) of children: _____

Name of your employer: _____

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

EMERGENCY INFORMATION

Person to contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____

INSURANCE INFORMATION

Insurance company name: _____ Group #: _____

ID/Social Security #: _____

Employer: _____

If spouse is your policy holder:

Spouse's date of birth: ____/____/____ Spouse's SS#: ____-____-____

Spouse's employer: _____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to L. Kevin Metsger, D.M.D.. Initials: _____

APPOINTMENT CANCELLATION POLICY

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advance notice of 24 hours.** We understand that conflicts arise; however, failing your appointment or canceling without adequate notice more than once will result in a no-show fee. Initials: _____

MEDICAL HISTORY

Please list all current **medications/vitamins/herbal supplements**:

_____ purpose _____

_____ purpose _____

_____ purpose _____

_____ purpose _____

_____ purpose _____

_____ purpose _____

(For women) Are you currently pregnant? yes no If yes, how many months? _____

Are you currently taking birth control? yes no If yes, name: _____

Are you currently or have you ever taken any bisphosphonates (Fosomax, Zometa, Boniva, Actonel, Reclast, other)? yes no If yes, name: _____

Do you know your blood pressure? yes no If yes, what is it? _____

Please check if you are allergic to any of the following:

Local anesthesia Sulfa drugs Codeine/other narcotics

Penicillin/other antibiotics Aspirin Latex sensitivity

Barbiturates, sedatives, sleeping pills Shellfish, iodine or red wine Other _____

Do you have, or have you ever had, any of the following?

<input type="checkbox"/> <input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> <input type="checkbox"/> Drug Addiction	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> <input type="checkbox"/> Rheumatism
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> <input type="checkbox"/> Easily Winded	<input type="checkbox"/> <input type="checkbox"/> Herpes	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> <input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Shingles
<input type="checkbox"/> <input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> <input type="checkbox"/> Hives or Rash	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> <input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> <input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/> Spina Bifida
<input type="checkbox"/> <input type="checkbox"/> Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Frequent Cough	<input type="checkbox"/> <input type="checkbox"/> Leukemia	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Breathing Problem	<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> <input type="checkbox"/> Bruise Easily	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Lung Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Tonsillitis
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> <input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Chest Pains	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> <input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> <input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> <input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Artificial Joint		

If yes, date placed: _____

