Tracy M. Clark, D.D.S
Diplomate, American Board of Endodontics

PATIENT INFORMATION

Date:____________________

Prefix: Mr. Mrs. Ms. Dr.

Patient Name:____
(Last) (First) (Middle) (nickname)

Address:____
(Street) (Apt#) (City) (State) (Zip code)

Phone:____________________ ________________________ __________________________
(Home) (Work) (Cell)

Email address:____________________________

Patient SS#:_________________________ Patient Driver's Lic#:______________________

Patient Birth Date:_____/_____/_____ Patient Gender: Male________ Female________

Patient Employer___________________________Occupation____________________________

Spouse/ Other Name:____

Employer:____

(If under 18) Parent Name:____________________________ Phone:_________________________

***Referring Dentist _______________________________________

DENTAL INSURANCE INFORMATION

Insured Name____ Ins SS#:__________________
(Last) (First) (Middle) Birth date_____/_____/_______

Employer:____

Insurance Co.:__________________________________ Group #:_______________________

Ins Co Address:____
(Street) (City) (State) (Zip)

Secondary Insurance:____

FINANCIAL POLICY AND INSURANCE ASSIGNMENT

I, the undersigned certify that I (or my dependent) have insurance coverage with the above stated company and assign directly to Dr. Clark all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event that the insurance company does not make a payment towards my account within 90 days, I will remit a payment for the full balance as expected. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ______/_____/_____
Responsible Party Signature Relationship Date

If dental insurance applies: Although this dental office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any differences of payment is entirely the responsibility of the patient.

INITIALS_________ DATE______

MEDICAL HISTORY

Please Indicate a YES/NO for each condition:

Previous Heart Attack/Stroke	YES/NO	Kidney Disease/Dialysis	YES/NO
Previous Heart Surgery	YES/NO	Epilepsy/Seizures	YES/NO
Mitral Valve Prolapse	YES/NO	Cancer	YES/NO
Heart Murmur/Rheumatic Fever	YES/NO	Radiation	YES/NO
Artificial Heart Valves	YES/NO	Chemotherapy	YES/NO
Pacemaker	YES/NO	Glaucoma	YES/NO
Artificial Joints	YES/NO	Hemophilia	YES/NO
Angina	YES/NO	Hepatitis A/B/C/D	YES/NO
High Blood Pressure	YES/NO	Drug Addiction	YES/NO
Thyroid Disease	YES/NO	AIDS/HIV	YES/NO
Tuberculosis	YES/NO	Pregnant (Females Only)	YES/NO
Asthma	YES/NO	Birth Control Pills	YES/NO
Ulcers	YES/NO	Have you ever used steroids?	YES/NO
Latex Allergy	YES/NO	Have you ever taken Phen-fen?	YES/NO
Sinus Trouble	YES/NO	Do you take anticoagulants?	YES/NO
Diabetes	YES/NO	Do you take a bisphosphonate?	YES/NO

Any Other Medical Conditions Not Listed: YES/NO
If Yes, please list: ______________________________

Please list all medications you are currently taking: ______________________________
____
____

Please list any drug allergies you have: ______________________________
Physician's Name: ______________________________
Physician's Phone #: ______________________________

***** Signature**: ______________________________ Date: ______________

In case of Emergency, please contact ______________________________
Address: ______________________________ Home #: ______________
Work #: ______________ Cell #: ______________ Relationship: ______________

For Office Use Only

Notes: ______________________________ Doctor: ______________________________
Blood Pressure: ______________________________ Date: ______________________________
Pulse: ______________________________ Updated on: ______________________________

Doctor's Comments:
____
____
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____
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