A B C

JACKIE L. BANAHAN, D.M.D.

WELCOME TO OUR PRACTICE!

Today's Date ____________________

If you have previously completed this form for another patient, please give that patient's name ____________

PATIENT INFORMATION

Name ____________________ Nickname, if any ____________

Address ____________________ Birthdate ____________ Age ________ Sex ______

City ____________ State ______ Zip ______ School, if student ____________ Grade ______

Home Phone (   ) ____________ If child, names and ages of brothers and sisters

If patient is a minor, give parent's or guardian's ____________________

names ____________________ Referred by: ____________

RESPONSIBLE PARTY

Email Address ____________

Full Name ____________________ Social Security # ____________

Address ____________________ Relationship to Patient ____________

City ____________ State ______ Zip ______ Employer ____________

Previous Addr. (if less than 3 yrs.) ____________ Occupation ____________ Years Employed ______

Cell Phone (   ) ____________ Spouse's Name ____________

Home Phone (   ) ____________ Spouse's Relationship to Patient ____________

Work Phone (   ) ____________ Spouse's Employer ____________

Birthdate ________ Marital Status ________ Spouse's Work Phone ____________

DENTAL INSURANCE INFORMATION - PRIMARY

We need a copy of your insurance card.

Insured's Name ____________________ Insured's Social Security # ____________

Insured's Birthdate ____________________ Insured's Employer ____________

Insurance Company ____________________ Address ____________

Address ____________________ Group # ____________ Local # ____________

DENTAL INSURANCE INFORMATION - SECONDARY

We need a copy of your insurance card.

Insured's Name ____________________ Insured's Social Security # ____________

Insured's Birthdate ____________________ Insured's Employer ____________

Insurance Company ____________________ Address ____________

Address ____________________ Group # ____________ Local # ____________

EMERGENCY INFORMATION

Nearest Relative Not Living With You:

Name ____________________ Address ____________

Telephone (   ) ____________ City ____________ State ______ Zip ______

RELEASE

I understand that the information I have given is correct to the best of my knowledge. I also authorize Dr. Banahan to perform the necessary dental treatment needed by the patient, which will be discussed with me in advance. I agree to be responsible for payment of all services rendered. I understand the parent or guardian accompanying a child is responsible for payment of all services. I authorize and request my insurance company to pay benefits directly to Dr. Banahan. If credit is extended, I understand that credit bureau reports may be obtained.

Signature (Parent's or guardian's signature, if minor) ____________________

Social Security # ____________________ Birthdate ____________ (of person signing)

PLEASE CONTINUE ON BACK

JACKIE L. BANAHAN, D.M.D.
HEALTH HISTORY

PLEASE ANSWER ALL QUESTIONS BY CIRCLING Y (yes) or N (no) ALL RESPONSES ARE KEPT CONFIDENTIAL

MEDICAL HISTORY

1. Please rate patient's medical health:
   ❐ Excellent ❐ Good ❐ Fair ❐ Poor
2. Has there been ANY change in patient's general health in the past year? .... Y N
3. Has patient had any serious illnesses, operations or hospitalizations? .... Y N
   If so, please describe:
   ____
   ____
4. Has patient had any history of:
   a. Rheumatic fever or heart murmur? .... Y N
   b. Heart, kidney, lung or liver disorders? . Y N
   c. Blood disease (anemia, bleeding tendency, blood transfusion)? .... Y N
   d. Epilepsy, seizures? .... Y N
   e. Cerebral palsy? .... Y N
   f. Diabetes? .... Y N
   g. Asthma? .... Y N
   h. Hearing impairment? .... Y N
   i. Hyperactivity? .... Y N
   j. Cancer? .... Y N
   k. Fingersucking, thumbsucking, pacifier, lip sucking, lip biting, nail biting, grinding teeth, jaw clenching, chewing hard objects? .... Y N
      (circle those that apply)
   l. Learning disabilities? .... Y N
      (if yes describe)______________________
   m. Frequent or recurring mouth sores? ..... Y N
   n. Recurrent infections of any kind? .... Y N
   o. Toothache, pain in/near ears, unhealed sores in/around mouth? .... Y N
   p. Problems with tooth extractions? .... Y N
   q. Unfavorable experience in a dental or medical office? .... Y N
   r. Does patient have any other disease, condition, or problem not listed above that you think the doctor should know about? .... Y N

5. Patient's physician & address:
   ____
   ____
6. Please list all MEDICATIONS patient is taking:
   ____
   ____
   ____
7. Please list all ALLERGIES:
   ____
   ____
   ____

DENTAL HISTORY

1. Date of patient's last dental visit?
   ____
2. Where? ______________________________
   ____
3. Were x-rays taken? .... Y N
4. Have Mother or Father had a lot of decay? .... Y N
5. Any dental problems that you are aware of at present? (If yes, list) .... Y N
   ____
   ____
6. Purpose of today's visit:
   ____
   ____
7. Remarks: ______________________________
   ____

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in the patient's medical status.

Signature of person completing health history ______________________ (relationship to patient) ______________________