

James A. Richardson DMD
Margaret H. Lunn DMD

Patient Information

Patient Name _____ Date of Birth ___/___/___

SSN _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-Mail _____

Referred by _____

Emergency Contact _____ Phone Number _____

Employer and Insurance Information

Person Responsible For Your Bill _____

Employer _____ Phone _____

Dental Insurance Co. _____ Group No. _____

Insurance Co. Address _____

Relationship to Subscriber: ___ Self ___ Spouse ___ Child

Subscriber's Date of Birth ___/___/___

Check the appropriate box:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis/Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Virus
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Nervous	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Use Tobacco Products	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Joint/Valve Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Rheum Fever
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pill						

Do you require Premedication? _____

Name of Physician _____ Phone Number _____

Taking Medications Yes No If yes, please list _____

Allergic to Medications Yes No If yes, please list _____

Date of Last Dental Treatment _____ Date of most recent X-Rays _____

Previous Dentist _____

What are your Dental Concerns? _____

The above information is true, to the best of my knowledge. I understand that I am responsible for payment of this account, regardless of insurance status. (Accounts 30 days past due will be charged a 2% monthly billing fee).

Patient Signature _____ **Date** _____