**Michael E. Judy D.D.S., Inc.**
**5919 Teletowne Drive • Suite 5**
**Toledo, Ohio 43612**

## PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential)

PATIENT'S LAST NAME FIRST NAME MIDDLE PREFERRED NAME

CURRENT STREET ADDRESS CITY STATE ZIP

PATIENT'S BIRTHDATE SOCIAL SECURITY NUMBER HOME PHONE WORK PHONE OTHER PHONE

SINGLE ________ MARRIED ________ SEPARATED ________ DIVORCED ________ WIDOWED ________

IF STUDENT, IN COLLEGE? ☐ YES ☐ NO IF EMPLOYED, EMPLOYER'S NAME ________________

IF PATIENT IS A CHILD, GUARDIANS NAME ________________ PHONE ________________

WHOM MAY WE THANK FOR REFERRING US? ________________ PHONE ________________

## RESPONSIBLE PARTY IF DIFFERENT

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT RELATIONSHIP

BILLING ADDRESS CITY STATE ZIP HOME PHONE

EMPLOYER SOCIAL SECURITY NUMBER WORK PHONE

## PRIMARY DENTAL INSURANCE

INSURED PERSON'S FULL NAME BIRTHDATE

SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT WORK PHONE

EMPLOYER'S NAME FULL ADDRESS OF EMPLOYER OCCUPATION

INSURANCE COMPANY NAME ADDRESS OF INSURANCE COMPANY GROUP OR LOCAL NUMBER

## SECONDARY INSURANCE IF YES, PLEASE COMPLETE THE FOLLOWING:

INSURED PERSON'S FULL NAME BIRTHDATE

SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT WORK PHONE

EMPLOYER'S NAME FULL ADDRESS OF EMPLOYER OCCUPATION

INSURANCE COMPANY NAME ADDRESS OF INSURANCE COMPANY GROUP OR LOCAL NUMBER

# MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Their name: ______________________

Their Phone: ______________________

Are you currently under care of any physician? ❑ Yes ❑ No

If yes, please explain: ______________________

Are you presently taking any drugs prescribed by a physician or dentist?

❑ Yes ❑ No If yes, please list: ______________________

For women: Are you pregnant? ❑ No ❑ Yes, Wk # __________

Why have you come to the dentist today? ______________________

Are you currently in pain? ❑ Yes ❑ No

The approximate date of your last dental visit: ______________________

## HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N Mitral Valve Prolapse
Y N Rheumatic Fever
Y N Enlarged Heart
Y N Congenital Heart Defect
Y N High / Low Blood Pressure
Y N Heart Murmur
Y N Heart Surgery / Pacemaker
Y N Artificial Valves
Y N Heart Attack / Stroke
Y N Artificial Joints
Y N Cancer
Y N HIV+/AIDS
Y N Arthritis
Y N Ulcers / Colitis
Y N Herpes (Cold Sore)
Y N Epilepsy / Seizures / Fainting Spells
Y N Asthma
Y N Hepatitis
Y N Difficulty Breathing
Y N Blood Transfusion
Y N Psychiatric Problems
Y N Drug / Alcohol Problems
Y N Kidney Problems
Y N Sinus Problems
Y N Severe / Frequent Headaches
Y N Diabetes
Y N Abnormal Bleeding
Y N Tuberculosis
Y N Nervous Problem
Y N Venereal Disease

Please list any other serious medical condition(s) that you have ever had: ______________________

## ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?

Y N Penicillin
Y N Dental Anesthetics
Y N Aspirin
Y N Codeine
Y N Erythromycin
Y N Latex
Y N Tetracycline
Y N Other

Please list any other drugs that you are allergic to: ______________________

THANK YOU for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

## CONSENT FOR TREATMENT

1. 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.
2. 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.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.
4. I understand that 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% finance charge (12% APR) may be added to my account.
5. Lastly, a booked appointment fee may be charged for cancellations & no shows if less than 24 hours.

Patient ______________________ Date ______________________