Dr. Wayne B. Erickson DDS **Erickson Family Dental Center** **307-746-4600**

MEDICAL HISTORY

Today's Date_____

Do you have or ever had any of the following diseases or Medical problems (circle Y for Yes or N for No)

Y N Heart Attack / Strokes
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV + / AIDS
Y N Heart Surgery / Pacemaker
Y N Shingles
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Artificial Bones / Joints
Y N Artificial Heart Valve
Y N Sinus Problems
Y N High / Low Blood Pressure
Y N Fever Blisters
Y N Severe/ Frequent Headaches
Y N Psychiatric Problems
Y N Epilepsy / Seizures / Fainting
Y N Diabetes / Tuberculosis
Y N Drug / Alcohol Abuse
Y N Venereal Disease
Y N Hemophilia / Abnormal Bleeding
Y N Ulcers / Colitis
Y N Congenital Heart Defect
Y N Anemia / Radiation Treatment
Y N Asthma / Arthritis
Y N Difficulty Breathing
Y N Hospitalized for any Reason
Y N Hepatitis
Y N Blood Transfusion
Y N Emphysema / Glaucoma

If any of the above are Yes please explain: _____
_____
_____

List any serious medical conditions that you have ever had: _____
_____

Are you allergic to any of the following drugs?

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

List other drugs you are allergic to: _____
_____

List other drugs you are currently taking: _____
_____

Y N Are you Pregnant? If so how many weeks? ____ Due Date_____
Y N Are you taking Aspirin or any other blood thinners (anti-coagulants)?
What and how much? _____

DENTAL HISTORY

Why have you come to the dentist today:_____
_____

Y N Are you currently in Pain?
Y N Have you ever had a serious / difficult problem associated with any previous dental work
Y N Do you like your smile?
Y N Do your gums ever bleed?
Y N Do you smoke or chew tobacco? How much _____
You current dental health is _____Good_____Fair_____Poor
How many times per week do you floss?_____
How many times per day do you Brush?_____
Your tooth brush is _____Hard_____Medium_____Soft

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. Please remember that payment is due in full at time of treatment unless prior arrangements have been approved.

CERTIFICATION

I hereby certify that the information listed on this form regarding medical and dental history is completely true and correct. It may be relied upon for all purposes by Dr. Wayne B. Erickson, assistants, colleagues, staff, employees and any other persons treating or assisting in the treatment of the patient.

Signature_____Date _____

You are the___Patient___Parent___Guardian

DENTIST AND ASSISTANT

_
We have visually and verbally reviewed the medical and dental information on this form with the patient, parent or guardian.

Initials_____ Date_____

MEDICAL AND DENTAL HISTORY UPDATES

1. Date_____ Comments_____Signature_____

2. Date_____ Comments_____Signature_____

3. Date_____ Comments_____Signature_____

4. Date_____ Comments_____Signature_____

5. Date_____ Comments_____Signature_____

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PATIENT REGISTRATION

In office account #_____ Today's Date_____ New ____ Update____

Patient_____ Age_____ Birthdate_____ Sex: M F Marital Status_____

Mailing address_____City_____State_____ Zip_____

Physical address_____City_____State_____ Zip_____

Home Phone_____ Cell Phone_____ Soc Sec. #_____Drivers License_____

Employer _____ Work Phone _____ Email _____

Spouse name_____ Birthdate _____ Phone _____ Soc Sec # _____

Spouse Employer _____ Work phone _____ Spouse Email _____

Emergency contact name/phone _____

Have you or a family member been here before? _____ Relationship to patient_____

How did you hear about our office?_____

INSURANCE INFORMATION

Dental Insurance? Yes No Copy of Card in Chart _____

Insured person's name _____ Phone _____ Birthdate _____

Soc. Sec. #_____ Employer _____ Patient Relationship to Insured___self___spouse____child

FINANCIAL AGREEMENT

For Non-Insured Patients- You are expected to pay 100% for services rendered on the date of service.
For Insured Patients - You are expected to pay for your portion of your visit when services are rendered. Your portioned amount charged, may not be an exact amount expected and additional charges after insurance has settled, in which you are responsible for.

_____
Authorized Signature

PROMISE TO PAY

I understand and agree that I am responsible to pay for all services provided to me by Erickson Family Dental Center. I agree to pay 50% or more of my bill on the date of service or my portion of the bill if I have insurance. Should this account be referred to a third party for collection or recovery, I will be responsible for all, reasonable attorney fees and court cost. I agree to pay interest accruing at the rate of 18% per year on all past due accounts.

_____
Authorized Signature

INSURANCE AGREEMENT

As a courtesy to our patients, we will complete insurance papers for you, however, our professional services are rendered to you and not to the Insurance Company, therefore, you are directly responsible for the cost of your treatment. I hereby authorize the release of any information relating to all insurance claims for benefits on behalf of myself and/or other dependents. I understand that it is my responsibility to inform Dr. Wayne B. Erickson of any changes of Insurance or any information that would effect the above information. If you wish your insurance benefits sent directly to Erickson Dental, please authorize with your signature.

_____
Authorized Signature

APPOINTMENT POLICY

Our overhead costs remain fixed for the time we have allotted for your appointment, therefore a $30.00 fee will be charged for missed appointments. Please call at least twenty-four hours before to cancel your appointments, otherwise you will be charged this fee.
Initials_____.

Please fill out reverse side of this form for your medical and dental history, Thank You.