Azle Family Dentistry-John E. Hoover, D.D.S.

Patient Name: _____Date_____

Last First MI (preferred name)

DL#_____Gender: **M F** Family Status: _____Birthdate_____age_____

Phone (Home)_____Cell/Other_____email _____

Address_____

Street City State Apartment#

Emergency contact name and phone number _____

Medical History

□ Anemia	□Heart Disease	□Radiation Treatment	**Penicillin** Allergy □Yes □No
□Artificial Joints	□Heart Murmur	□Respiratory Disease/problems	**Codeine** Allergy □Yes □No
□Asthma	□Hepatitis	□Rheumatism	**Any Other Drug Allergies?** □Yes □No
□Blood Disease	□High Blood Pressure	□Stomach Problems	If yes, please list
□Chemotherapy	□HIV/AIDS	□Stroke	_____
□Cortisone Treatments	□ Jaundice	□Tobacco Habit	_____
□Diabetes	□ Kidney Disease	□Thyroid Problems	_____
□Dizziness	□Liver Disease	□TMJ	**Other** Medical Conditions not listed?
□Epilepsy	□Mitral Valve Prolapse	□Tuberculosis	□Yes □No
□Excessive bleeding	□Mental Disorder	□Tumors	_____
□Fainting	□Nervous Disorder	□Ulcers	
□Glaucoma	□OSA (Obstructive Sleep Apnea	□Venereal Disease	_____
□Growths	Do you Snore? □ Yes □NO		
□Head Injuries	□Pacemaker		
	□Parkinson's disease		

*(**Women)** Are you pregnant □Yes □No **Nursing** □Yes □No Take Birth Control Pills □Yes □No

Date of last dental visit_____Reason for visit_____

Do you have tooth pain? □YES □ NO_____

Have you ever had any complications from dental treatment? □**Yes** □**No if yes, please explain** _____

Have you been admitted to the hospital or had any major surgeries in the last 2 years? □**Yes** □**No** _____

Are you currently taking any medications? □**Yes** □**No** if yes, please list all of medications and their reason: _____

_____

Are you currently under the care of a Physician? □**Yes** □**No if yes, please explain**_____

Name of Physician _____**Phone**_____

_____

Signature of patient, parent or guardian **Date**

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Responsible Party

Person Responsible for Account_____
Last Name **First Name** **Middle Initial**

Relationship to Patient_____Birthdate_____SSN_____

City_____State_____Zip_____

Person Responsible Employed By_____Occupation_____

Business Address_____Business Phone_____

Primary Insurance

Dental Insurance Company Name_____

Subscriber ID#_____Group#_____

Names of other dependents covered by this plan_____

Is patient (or dependent) covered by additional insurance? □ Yes □ No If yes, please complete additional insurance information

Authorization

I certify that I, and/or my dependent(s) have insurance with _____and
Dental Insurance Company Name

Assign directly to **Dr. John Hoover**, 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***. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is finished or one year from the date signed below.

I grant my permission to you or your assignee, to telephone me at home, cell or at my work to discuss matters related to this form.

I UNDERSTAND IF I DO NOT GIVE 24 HOURS NOTICE BEFORE BREAKING OR RESCHEDULING AN APPOINTMENT I MAY BE CHARGED A FEE. I have read the above conditions of treatment and payment and agree to their content**.**

_____**Date**_____
Signature of patient, parent or guardian

_____ **Date**_____
Signature of guarantor of payment/responsible part