

GARDEN HOME DENTAL

Patient Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth: _____ Social Security # _____

Sex: Male Female Married Single Child

Phone _____ Work _____ Cell _____

Email _____

Who may we thank for referring you? _____

Primary Dental Insurance/Responsible Party

(please complete if someone other than the patient is responsible for the charges)

Dental Insurance Subscriber _____ DOB _____

Relation to Patient _____ Social Security # _____

Address (if different than patient) _____

City _____ State _____ Zip _____

Insurance Company _____ ID # _____

Group # _____ Insurance Phone # _____

Additional Dental Insurance

Is patient covered by other insurance? Yes No

Dental Insurance Subscriber _____ DOB _____

Relation to Patient _____ Social Security # _____

Address (if different than patient) _____

City _____ State _____ Zip _____

Insurance Company _____ ID # _____

Group # _____ Insurance Phone # _____

Dental History

Former Dentist _____ Last Visit _____ Last X-rays _____

Medical History

Physician's Name _____ Date of last exam _____

Have you had any serious illness or operations? Yes No Blood Transfusion? Yes No

If yes, please describe _____

Check box if you have ever taken: "fen-phen" Fosomax Zomata Boniva

(Women) Are you pregnant? Yes No Nursing Yes No Taking birth control Yes No

Check box if you have or have had any of the following:

- | | | | |
|-----------------------------------------------|----------------------------------------------|------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Surgical Implant |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever | |

Medications _____

Allergies _____

Authorization

The information I have provided is accurate and complete to the best of my knowledge. I understand it will be used for my treatment, billing and processing of my insurance benefits for which I am entitled. I certify all insurance benefits to be paid directly to Dr. Bradley Handick 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. In the event that payment in full is not made and requires a collection agency for charges incurred, I agree to pay all cost of collections including a collection fee of \$75.00, attorney fees, court costs and interest at the rate of 1.5% per month (18% per annum).

Signature of Patient, Guardian, or Personal Representative

Date

Please Print Name of Patient, Guardian, or Personal Representative

Date