HEALY DENTAL CARE
JAMES R. HEALY D.D.S.

548 12th Street
Ogden, Utah 84404

PATIENT INFORMATION Date ____________

Name ______________________________ Birth Date ______________

SS Number ____-____-________ Home Phone ____________ Work ____________

E-Mail Address ______________________________ Cell ____________

Address ______________ City ____________ State ________ Zip ________

Drivers License # ______________________________ State ____________

IN CASE OF EMERGENCY

Nearest relative not living with patient ______________________________

Address ______________ City ____________ State ________ Zip ________

Home Phone ______________ Day Phone ______________

Friend or neighbor ______________________________ Phone ____________

Address ______________ City ____________ State ________ Zip ________

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name ______________ Birth Date ____________ SS Number ____-____-____

Employer ______________________________ Work Phone ____________

Spouse ______________ Birth Date ____________ SS Number ____-____-____

Employer ______________________________ Work Phone ____________

Home Address ______________ City ____________ State ________ Zip ________

Home Phone ______________

INSURANCE INFORMATION

1st Insurance Co. ______________________________ Policy # ____________

Address ______________________________ Group # ____________

2nd Insurance Co. ______________________________ Policy # ____________

Address ______________________________ Group # ____________

FINANCIAL AGREEMENT

____________ 5% Discount for cash at time of treatment.

____________ Insurance Co-payment due at time of service.

____________ How will you be handling your account - Cash, Check or Credit Card?

How were you referred to our office? ______________________________

I agree to pay account in full within 30 days of statement. I agree to pay 1 1/2% service charge per month on any past due balance plus cost of collection and reasonable attorney fees. I also authorize release of any information relating to claims. I understand that, where appropriate, credit bureau reports may be obtained.

Signature ______________________________ Date ____________
(Patient or legal guardian or parent of patient)

MEDICAL HISTORY

Name of Medical Doctor ______________________________ Phone ____________

Are you in pain? Yes ________ No ________

Are you in good health? Yes ________ No ________

Are you now under a physician's care? Yes ________ No ________

Do you take medicine? What? ______________________ Yes ________ No ________

Are you pregnant? Yes ________ No ________

Have you ever had heart or blood trouble? Yes ________ No ________

When ______________________________

Have you ever had a heart murmur? When? ______________________ Yes ________ No ________

Have you even had rheumatic fever? Yes ________ No ________

Have you ever had hepatitis? When? ______________________ Yes ________ No ________

Do you bleed or bruise easily? Yes ________ No ________

Do you have Asthma __________ Blood Disorder __________ Diabetes __________ Arthritis __________

Rheumatism __________ Tuberculosis __________ Venereal Disease __________ or other

constitutional disorders? Specify ______________________________

Have you ever had a blood transfusion? When? ______________________ Yes ________ No ________

Have you ever had or been treated for acquired immune deficiency syndrome (AIDS), chronic pneumonia, Kaposi's sarcoma, heart disorder, cancer, alcoholism or alcohol abuse, drug use or addiction, or stroke?

____

Specify ______________________________

Do you have abnormal blood pressure? S __________ D __________ Yes ________ No ________

Have you ever taken, or are you currently taking, Fosamax, Aredia, Actonel or Zometa for the treatment of Osteoporosis, Osteosarcoma or Post-Menopausal bone lose? When? __________ Yes ________ No ________

ARE YOU ALLERGIC TO:

Penicillin ______________________ Local anesthetic __________ Medication or drugs?

Specify ______________________________

When did you see your dentist last? ______________________________

Have you ever had a severe reaction to a dental treatment? ______________________________

Are you subject to fainting? Yes ________ No ________

Any other medical problems we should be aware of? ______________________________

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Reviewed Medical History __________ **Date** __________

INFORMED CONSENT

The dental treatment necessary to my existing oral condition(s) has been explained to me and my questions have been answered satisfactorily. I hereby authorize Doctor James R. Healy, D.D.S. and/or such associates or assistants as he may designate to perform those procedures, including surgery, as may be deemed necessary or advisable to my dental treatment, including arrangement and/ or administration or any anesthetic, sedative, analgesic, therapeutic and/or other pharmaceutical agent(s), including those related to restorative, palliative, surgical, anesthetic, sedative, analgesic, medicinal or drug treatment(s) and do voluntarily assume the possible risks with these procedures.

Signature ______________________________ Date ______________

(Patient or legal guardian or parent of patient)

REORDER # 06-17833