CRAIG T. DAVIS, JR., DDS DILLON HOWELL DDS
906 ENTERPRISE DRIVE • JONESBORO, AR 72401

Responsible Party Information

Name ______________________________ Marital Status __________
Last First Middle

Residence ______________________________ ☐ Own ☐ Rent
Street City State Zip

Mailing Address ______________________________ Email __________
Street City State Zip

How Long at This Address __________ Previous Address ______________________________
(If Less Than 3 Years) Street City State Zip

Primary Phone ______________________________ Work Phone __________

Social Security # __________ Birth Date __________ Relationship to Patient __________

Employer __________ Occupation __________ No. Years Employed __________

Spouse's Name ______________________________ Relationship to Patient __________
Last First Middle

Employer __________ Occupation __________ No. Years Employed __________

Social Security # __________ Birth Date __________ Work Phone __________

Confidential Patient Information (If different from above)

Patient's Name ______________________________
Last First Middle

Address ______________________________
Street City State Zip

Home Phone __________ Birth Date __________ Social Security # __________

If patient is a minor, give parent's or guardians name ______________________________

Whom may we thank for referring you to our office? ______________________________

Emergency Information

Name of nearest relative not living with you ______________________________

Complete Address ______________________________
Street City State Zip

Phone __________ Relationship ______________________________

Insurance Information

Policy Holder's Name ______________________________ Social Security # __________

Insurance Company ______________________________ Group No. __________

Insurance Co. Address ______________________________ Insurance Co. Phone __________

Policy Holder's Employer ______________________________

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name ______________________________ Social Security # __________

Insurance Company ______________________________ Group No. __________

Insurance Co. Address ______________________________ Insurance Co. Phone __________

Policy Holder's Employer ______________________________

I agree to be responsible for all charges for dental service and materials not paid for by my dental benefits plan. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. I certify that I can read and understand the above information. I will not hold Dr. Davis, Dr. Howell, or any members of their staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient (if minor, signature of parent or guardian) ______________________________ Date __________

Sex: Circle One:
Male
Female

If female, please answer the following:	Y	N
Are you taking birth control pills?	☐	☐
Are you pregnant? If yes, how many weeks?______	☐	☐
Are you nursing	☐	☐

PLEASE NOTE:
ANTIBIOTIC MEDICATIONS PRESCRIBED BY THE DENTIST FOR INFECTION CAN REDUCE THE EFFECTIVENESS OF YOUR BIRTH CONTROL MEDICATION!

Do you have, or have had any of the following?

	Y	N
Abnormal Bleeding	☐	☐
Alcohol Abuse	☐	☐
AIDS/HIV Positive	☐	☐
Alzheimer's Disease	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis/Gout	☐	☐
Artificial Heart Valve	☐	☐
Artificial Bones or Joints	☐	☐
Asthma	☐	☐
Blood Disease	☐	☐
Blood Transfusion	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chemotherapy	☐	☐
Colitis	☐	☐
Congenital Heart Disorder	☐	☐
COPD	☐	☐
Cosmetic Surgery	☐	☐
Convulsions	☐	☐
Diabetes	☐	☐
Difficulty Breathing	☐	☐
Drug Addiction	☐	☐
Emphysema	☐	☐

	Y	N
Epilepsy or Seizures	☐	☐
Fainting Spells/Dizziness	☐	☐
Fever Blisters	☐	☐
Frequent Headaches	☐	☐
Glaucoma	☐	☐
Hay Fever	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Heart Pacemaker	☐	☐
Heart Surgery	☐	☐
Hemophilia	☐	☐
Hepatitis A	☐	☐
Hepatitis B or C	☐	☐
High Blood Pressure	☐	☐
Irregular Heart Beat	☐	☐
Kidney Problems	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Lung Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Osteoporosis	☐	☐
Pain in Jaw Joints	☐	☐
Psychiatric Problems	☐	☐
Radiation Therapy	☐	☐
Recent Weight Loss	☐	☐

	Y	N
Renal Dialysis	☐	☐
Rheumatic Fever	☐	☐
Shingles	☐	☐
Sickle Cell Disease	☐	☐
Sinus Problems	☐	☐
Thyroid Problems	☐	☐
Tuberculosis	☐	☐
Tumors or Growths	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Yellow Jaundice	☐	☐

Are you Allergic to any of the following?

	Y	N
Aspirin	☐	☐
Codeine	☐	☐
Dental Anesthetics	☐	☐
Erythromycin	☐	☐
Jewelry	☐	☐
Latex	☐	☐
Metals	☐	☐
Penicillin	☐	☐
Sulfa	☐	☐
Tetracycline	☐	☐

Other:______________________________

Have you had a serious illness not listed? ☐ **Yes** ☐ **No**

If yes: ____

Are you under a physicians care now? YES or NO

If yes, please explain ______________________________

Have you ever been hospitalized or had a major operation? YES or NO

If yes, please explain ______________________________

Have you ever had a serious head or neck injury? YES or NO

Are you taking **ANY** medications? YES or NO

If yes, please explain ______________________________

Do you use tobacco? YES or NO

Do you use controlled substances? YES or NO

Are you taking blood thinner? YES or NO

Are you being treated for Osteoporosis? YES or NO

If yes, list medications ______________________________

Do you require a Pre-med before treatment? YES or NO

What is the name of your medical physician? ____________________

Who was your previous dentist? ____________________

Date of last visit? (Approximate) ____________________

Are you interested in keeping your natural teeth for the rest of your life? YES or NO

Are you unhappy with the color of your teeth? YES or NO

Do you catch food between your teeth? YES or NO

Do your gums bleed? YES or NO

Do you have persistent bad breath? YES or NO

Are you having any problems with your teeth? YES or NO

If yes, please explain ______________________________

Would you like to change anything about your smile? YES or NO
(I.E. whitening, straightening, lengthening, or white fillings, etc...)
If yes, please explain

____