Brian E. Himelwright, D.D.S., P.C.

8 Sheridan Square, Suite 100 ~ Kingsport, TN 37660
www.himelwrightdds.com
423-247-7731

Date: _____

Name: _____ Phone HM: _____ WK: _____ Cell: _____

Address: _____ Birth Date: _____

City: _____ State: _____ Zip: _____ Physician Name: _____

Employer: _____ Social Security #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Parent or Guardian (if under 18) _____

How do you prefer to be contacted: ___Home ___Work ___Cell ___Email

Person to contact in case of emergency: _____ Relationship _____ Phone _____

Dental Insurance

1. _____

2. _____

Who carries the insurance (circle one) Patient Spouse Mother Father

Have you ever had or do you have:

Asthma, hay fever, sinusitis, allergies?	Yes	No
Allergy to any drug/medications? - Specify_____	Yes	No
Blood pressure or heart problems?	Yes	No
Rheumatic fever, heart murmurs, joint replacement?	Yes	No
Pacemaker or open heart surgery, or valve repair/replacement?	Yes	No
Has a physician advised you to take antibiotics for dental care?	Yes	No
Diabetes, liver, kidney, thyroid or lung problems?	Yes	No
Hepatitis or jaundice?	Yes	No
Ulcers or stomach problems?	Yes	No
Epilepsy or nervous disorder?	Yes	No
Bleeding or clotting disorder?	Yes	No
Arthritis?	Yes	No
Any other illness? - Specify_____	Yes	No
Do any wounds heal slowly or with complications?	Yes	No

What medications do you presently take? _____

_____

For what condition? _____

Are you presently under the care of a physician?	Yes	No
Have you ever been hospitalized?	Yes	No
Have you had radiation treatments or chemotherapy?	Yes	No
WOMEN: Are you pregnant?	Yes	No
AIDS or HIV?	Yes	No

_____ _____

Patient Signature Date Doctor Signature Date

PLEASE CONTINUE ON BACK

Dental History

Do you have a family history of gum disease?	Yes	No
When was your last dental visit? _____		
When were your last dental x-rays taken? _____		
Do you have pain in your jaw or near your ears?	Yes	No
Do you have any growths or sore spots in your mouth?	Yes	No
Does any part of your mouth hurt when clinched?	Yes	No
Have you ever had difficulty getting numb for dental treatment?	Yes	No
Have you ever had an adverse reaction to getting numbed?	Yes	No
Have you ever had a reaction to local or general anesthetics?	Yes	No
Are you aware of having the tendency to clinch or grind your teeth?	Yes	No

Referral Information

Whom may we thank for referring you to our practice? ___Another Patient: Friend ___ Another Patient: Relative

___ Yellow Pages ___Newspaper ___ Website/Internet ___ Another Professional Office

Name of person referring you to our practice: _____

Consent for Services

To the best of my knowledge the above information is correct. I will inform this office of any changes.

I consent to the taking of photographs and x-rays before, during and after treatment and to the use of same by the doctor in scientific presentations or demonstrations.

Insurance: We provide services to our patients with the understanding that they are responsible for payment. We will prepare and submit forms to assist you in obtaining maximum benefits available, but this office cannot render services on the assumption that our charges will be paid by an insurance company.

Collections: I understand, that where appropriate, credit bureau reports may be obtained. In the event the balance becomes more than 60 days overdue, billing may be turned over to an outside collections agency. The responsible party listed above agrees to pay interest, collection, and other legal expenses related to collection of fees owed. Waiver of any breach of any term or condition shall not constitute a waiver of any further term or condition.

_____

Signature (Parent or Guardian if patient is a minor) Date