SCOTT M. BLAKE, D.D.S., P.C.

ORAL & MAXILLOFACIAL SURGERY
333 S. Woodruff
IDAHO FALLS, ID 83401
(208) 523-2160

PATIENT INFORMATION

DATE: ____________

Name: ______________________ (LAST / FIRST / M) Age: ________ ❑ Married ❑ Single ❑ Male ❑ Female

Address: ______________________ (STREET / APT# / CITY / STATE / ZIP)

Birthdate ____________ (MO / DAY / YR.) Telephone: ❑ ____________ (HOME#) ❑ ____________ (WORK#)

Employment (or School): ____________ Occupation: ____________ SS# ____________

Email Addresses: ______________________

Dental Insurance Co.: ____________ Group No. ____________

Has any member of your family ever been treated in our office? ❑ Yes ❑ No

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

FAMILY INFORMATION

CHECK ONE:

	❑ Father ❑ Husband	❑ Mother ❑ Wife
Name:	LAST / FIRST / M	LAST / FIRST / M
Address:	STREET / CITY / STATE / ZIP	STREET / CITY / STATE / ZIP
Telephone #:	HOME # / WORK#	HOME # / WORK#
Birthdate/SS #:	MO / DAY / YR / SS#	MO / DAY / YR / SS#
Employer:	EMPLOYER / OCCUPATION	EMPLOYER / OCCUPATION
Dental Insurance Co.:	DENTAL INSURANCE / GROUP #	DENTAL INSURANCE / GROUP #

PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE:
❑ Patient ❑ Father ❑ Husband ❑ Mother ❑ Wife ❑ Guardian

METHOD OF PAYMENT

Does Responsible Party currently have an account with this office? ❑ YES ❑ No

- ❑ Payment in full at each appointment.
- ❑ Credit Card: M.C. or VISA
- ❑ Insurance and balance in cash

FINANCE CHARGE. If I do not pay the entire New Balance within 90 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of $2.00) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last months balance. In case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

Name: ______________________ (LAST / FIRST / M) Tel # ____________

Address: ______________________ (STREET / CITY / STATE / ZIP)

AUTHORIZATION

I hereby authorize payment directly to Scott M. Blake, D.D.S., P.C. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

x ______________________ DATE ____________

❑ Adult Patient ❑ Father ❑ Husband ❑ Mother ❑ Wife ❑ Guardian

PATIENT INFORMATION

Height______________ Weight______________

Medical doctor's name ______________________________

Dentist's name ______________________________

Are you under a doctor's care now? Why? ______________________________ ❑ YES ❑ NO

Have you been hospitalized during the past two years? Why ______________________________ ❑ YES ❑ NO

Are you taking any medications, pills, or drugs? What? ______________________________ ❑ YES ❑ NO

Are you pregnant? (women)______________ Delivery Date ______________________________ ❑ YES ❑ NO

Please **circle** if you have had any of the following:

Heart Trouble	Chest Pain	Asthma	Thyroid Disease	Drug Addiction
High Blood Pressure	Shortness of Breath	Hay Fever	Parathyroid Disease	Abnormal Bleeding
Anticoagulant Therapy	Swelling of Feet/Ankles/Hands	Sinus Trouble	X-ray or Cobalt Tmt.	Blood Transfusion
Heart Murmur	Fainting or Dizziness	Emphysema	Chemotherapy/Radiation	Hemophilia
Rheumatic Fever	Stroke	Frequent Cough	Arthritis/Gout	AIDS
Congenital Heart Lesion	Diabetes	Lung Disease	Pain in Jaw Joints	Venereal Disease
Artifical Heart Valve	Excessive Thirst	Tuberculosis	Cortisone Medicine	Herpes
Heart Pacemaker	Artifical Joints/Hips	Liver Disease	Glaucoma	Cancer
Heart Surgery	Kidney Trouble	Hepatitis A (infec.)	Epilepsy or Seizures	Hypoglycemia
Blood Disease	Ulcers	Hepatitis B (serum)	Nervousness	Bruise Easily
Anemia	Allergies	Yellow Jaundice	Psychiatric Care	Sickle Cell Anemia
				Herbal Supplement

Are you allergic or have you had a reaction to:

a. Local anesthetics
b. Penicillin or other antibiotics
c. Sulfa drugs
d. Barbiturates, sedatives, or sleeping pills
e. Aspirin
f. Iodine
g. Codeine or other narcotics
h. Other______________

Additional comments about any of the above ______________________________

____

Have you had any serious trouble with any previous dental treatment?................ ❑ YES ❑ NO
If so, explain ______________________________

____

Have you ever had any other serious illness not circled above?................ ❑ YES ❑ NO
Please describe in detail ______________________________

____

What is your chief Oral or Dental problem today? ______________________________

____

For completion by dentist.

Comments on patient interview concerning medical history: ______________________________

____

____

Significant findings from questionnaire or oral interview: ______________________________

____

____

Dental management considerations: ______________________________

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______________________ ______________________________
Date Signature of Dentist

PATIENT INFORMATION

I have read my MEDICAL HISTORY dated______________ and confirm that it adequately states past and present conditions.

Date	Patient's Signature	Reviewed By
______________	______________________	DR. ______________
______________	______________________	DR. ______________
______________	______________________	DR. ______________
______________	______________________	DR. ______________