

ARBORETUM FAMILY DENTISTRY-- JOHN L. BISHOP, D.D.S.
3135 Springbank Lane, Suite 210
Charlotte, North Carolina 28226

Date: _____

Patient Name: _____

Address: _____

CITY STATE ZIP

Sex: M F Age: _____ Birthdate: _____

Single Married Widowed Separated Divorced

Patient Social Security Number: _____

Employer: _____

Occupation: _____ Department: _____

Employer Address: _____

Spouse or Parent's Name: _____

Birthdate: _____ Employer: _____

How did you hear about our office? Please list name(s) here:

OR (circle one)

Yellow Pages Outdoor Sign Insurance Co.

PRIMARY DENTAL INSURANCE

Name of insured: _____

Social Security #: _____ Birthdate: _____

Relationship to patient: _____

Insured's place of employment: _____

Address and phone of employment: _____

Dental insurance company: *(please be sure to list dental – not medical or prescription card information)*

Group no. _____ Telephone no. _____

Address: _____

SECONDARY DENTAL INSURANCE

Name of insured: _____

Social Security #: _____ Birthdate: _____

Relationship to patient: _____

Insured's place of employment: _____

Address and phone of employment: _____

Dental insurance company: _____

Group no. _____ Telephone no. _____

Address: _____

HAS ANY MEMBER OF YOUR HOUSEHOLD EVER SEEN DR. BISHOP? YES NO

PHONE NUMBERS

Home: () _____ Work: () _____ Ext or Dept: _____ Spouse's Work: _____

Best time and place to reach you? _____ Is Work a school #? Yes No

****MUST BE COMPLETED****

IN CASE OF EMERGENCY, CONTACT *(Specify someone who does not live in your household.)*

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____

City/State: _____

Date of last dental visit: _____

Date of last dental X-Rays: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath: Yes No

Bleeding gums: Yes No

Blisters on lips or mouth: Yes No

Burning sensation on tongue: Yes No

Chew on one side of mouth: Yes No

Cigarette, pipe, or cigar smoking: Yes No

Clicking or popping jaw: Yes No

Dry mouth: Yes No

Fingernail biting: Yes No

Food collection between the teeth: Yes No

Foreign objects: Yes No

Grinding teeth: Yes No

Gums swollen or tender: Yes No

Jaw pain or tiredness: Yes No

Lip or cheek biting: Yes No

Loose teeth or

broken fillings: Yes No

Mouth breathing: Yes No

Mouth pain, brushing: Yes No

Orthodontic treatment: Yes No

Pain around ear: Yes No

Periodontal treatment: Yes No

Sensitivity to cold: Yes No

Sensitivity to heat: Yes No

Sensitivity to sweets: Yes No

Sensitivity when biting: Yes No

Sores or growths in your mouth: Yes No

How often do you floss? _____

How often do you brush _____

HEALTH HISTORY

Physicians Name: _____ Date of last visit: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | |
|------------------------------------------------------|----------------------------------------------------------|------------------------------------------------|----------------------------------------------------------|-------------------------------------|----------------------------------------------------------|
| AIDS: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type: _____ | | Sinus Trouble: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease: | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer: | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Feet or Ankles: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatment: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you wear contact lenses?: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Women: Are you pregnant? Due date? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you nursing? Psychiatric Care: | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

MEDICATIONS

List medications you are currently taking:

Pharmacy Name: _____
Phone: _____

ALLERGIES

| | |
|--------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

I, _____, UNDERSTAND THAT I AM REPOSNSIBLE FOR THE TOTAL AMOUNT OF CHARGES FOR SERVICES RENDERED EACH VISIT. IF I HAVE INSURANCE, I UNDERSTAND THAT, AS A COURTESY, THIS OFFICE WILL GLADLY PROCESS MY DENTAL CLAIM. THE OFFICE REQUESTS THAT I PAY IN FULL UNTIL CONSIDERED A PATIENT OF RECORD (that is, having had a comprehensive exam with our hygienist.) IF I COMPLETE AND TURN IN AN INSURANCE FORM, THIS OFFICE WILL BE GLAD TO REIMBURSE ME IF INSURANCE COVERS ANY OF TODAY'S VISIT.

IF A PATIENT OF RECORD, I UNDERSTAND THAT I PAY MY ESTIMATED PORTION AT THE TIME SERVICES ARE RENDERED. I ALSO UNDERSTAND THAT IT IS ONLY AN ESTMIATE AND I AGREE TO PAY ANY BALANCE LEFT ONCE MY INSURANCE COMPANY HAS PAID ITS PART.

IN THE EVENT THAT I AM UNABLE TO FULFILL MY FINANCIAL OBLIGATIONS, THE ABOVE NAME IS RESPONSIBLE FOR THE UNPAID BALANCE AND ALL COLLECTION FEES AND/OR ATTORNEY FEES INCURRED DUE TO NON-PYAMENT OF MY ACCOUNT.

SIGNATURE OF RESPONSIBLE PERSON/PARENT Date: _____

PLEASE DO NOT WRITE BELOW THIS LINE

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