BARKLEY BOULEVARD DENTAL CARE
LES SEELYE, DDS

We are pleased you have selected us to provide dental care for you and your family.
How did you hear about our office? Friend/Family____ Website____ Insurance____ Mailer____ Other____
Name of family or friend who referred you_____

PATIENT INFORMATION

Last Name_____ First Name_____ Middle initial_____

Preferred Name _____ Birthdate_____

Address_____City_____State_____Zip_____

Mailing address _____

Primary Contact Phone ( ) _____ Home / Cell / Work (please circle one)

Secondary Contact Phone ( )_____ Home / Cell / Work (please circle one)

May we leave a message at home or on voicemail? YES/NO

Email address_____

Social Sec.#_____ Sex M F Mar.Status____

Employer _____

Spouse's Name_____Phone # ( ) _____

Emergency Contact_____Phone # ( ) _____

Nearest relative not living with you_____Phone # ( )_____

RESPONSIBLE PARTY (*If under 18 years of age*)

Name of Person Responsible for Account_____ Relationship to Patient_____

Mailing Address_____City_____State_____Zip_____

Phone# ( )_____Social Sec.#_____ Birthdate_____

INSURANCE INFORMATION

Subscriber/Insured's Name_____ Social Sec.#_____

Subscriber/Insured's Employer_____Birthdate_____

Insurance Company_____Group#_____

Insurance Company Address_____Subsc.ID#_____

Do you have secondary insurance? Yes / No

(more on other side)

MEDICAL INFORMATION

Have you been hospitalized or under the care of a medical doctor in the last 2 years
Other than routine visits. .....Yes No
Please list any medications you are currently taking_____
_____
_____

Have you ever taken bisphosphonates or other meds for Osteoporosis? _____

Are you sensitive or allergic to any medications……....Yes No
_____
Have you used or do you currently use tobacco products? If yes, which one:_____

Please circle to indicate which of the following you have had or have at the present.

Allergy to Latex	Cold Sores/Fever Blisters	HIV positive/AIDS
Allergy to Metal	Diabetes	Kidney Trouble
Allergies or Hives	Substance Abuse	Liver Disease
Anemia	Epilepsy/Seizures	Mitral Valve Prolapse
Angina Pectoris	Fainting/Dizziness	Osteoporosis
Arthritis	Heart Attack	Pacemaker
Artificial Heart Valve	Heart Disease	Radiation Therapy
Artificial Joints	Heart Murmur	Rheumatic Fever
Asthma	Heart Surgery	Stroke
Cancer	Hepatitis A B C	Thyroid Problems
Chemotherapy	High Blood Pressure	Tuberculosis

Do you have or have you had any disease, condition or problem not listed?.....Yes No
If yes, please list:_____
_____

For Women: Are you pregnant? Yes No Are you nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and best to my knowledge.

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with the patient. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor may choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a finance charge may be added to my account and my account may be sent to a collection agency.
4. I understand that it is my responsibility to advise your office of any changes in the information on this form and the use of my social security number to file my claim.

Patient or Responsible Party Signature: _____Date:_____

Office use only: _____