

C. CLAYTON WALKER, III, D.D.S.

- FAMILY DENTISTRY -

4405 JUNCTION PARK DRIVE • WILMINGTON, NORTH CAROLINA 28412 • (910) 350-6944

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

ADDRESS _____
STREET APT. # CITY STATE ZIP

PREVIOUS ADDRESS (if at present address less than two years) _____

BIRTHDATE _____ DRIVERS LICENSE _____
MO DAY YR STATE LICENSE #

TELEPHONE _____
HOME WORK CELL

EMPLOYER (OR SCHOOL) _____ GRADE _____ SS# _____

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

SPOUSE OR PARENT

Name _____ Address _____
LAST FIRST M STREET CITY STATE ZIP

Birthdate _____ Telephone _____ SS# _____
HOME WORK

Employer _____

Dental Insurance Co. _____ Group No. _____

PERSON RESPONSIBLE FOR ACCOUNT

Check One: Patient Father (or husband) Mother (or Wife) Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

Name _____ Telephone _____
LAST FIRST M

Address _____
STREET CITY STATE ZIP

METHOD OF PAYMENT

- Payment in full at each appointment by cash, check or bank card.
 On extensive treatment, I elect to pay 50% of my out-of-pocket portion on the preparation date and the balance on completion or delivery date.

FINANCE CHARGE. If I do not pay the entire New Balance within 60 days of service 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 which is an ANNUAL PERCENTAGE RATE of 18% applied to last month's balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge. I/we authorize Dr. Walker to investigate my/our credit and employment history. I/we understand you will retain this information whether or not credit is approved.

SIGNATURE OF RESPONSIBLE PARTY

X _____ Date _____

- Adult Patient Father (or Husband) Mother (or wife) Guardian

PATIENT NAME

(FULL NAME)

LAST

FIRST

MIDDLE

DATE

Primary reason for this dental appointment: Examination Emergency Consultation

DENTAL HISTORY

PLEASE CIRCLE

Do you have a specific dental problem? Describe... YES NO
Do you have dental examinations on a routine basis? Last visit... YES NO
Would you describe your present dental health as good? Comments... YES NO
Do you brush and floss on a routine basis? Discuss... YES NO
Do you want to keep your remaining teeth?... YES NO
Do you like your smile? Why?... YES NO
Do you think you have active decay or gum disease?... YES NO
Do your gums ever bleed? Discuss... YES NO
Do you feel nervous about having dental treatment?... YES NO
Have you ever had a bad experience in a dental office? Describe... YES NO
Name of previous dentist (optional)... Who referred you to our office?...
Do you ever brux or grind your teeth? Discuss... YES NO
Have you ever had orthodontic treatment (tooth straightening)?... YES NO
Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Discuss... YES NO

MEDICAL HISTORY

Medical doctor's name...
Are you under a doctor's care now? Why?... YES NO
Have you been hospitalized or received a blood transfusion? When?... YES NO
Are you taking any medications, pills, or drugs? What?... YES NO
Are you allergic to any medications or substance?... YES NO
Are you pregnant? (women)... YES NO

Please CIRCLE if you have had any of the following:

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

Have you ever had any other serious illness not circled above?... YES NO
Please describe in detail...
Do you wish to talk to the doctor privately about any problem?... YES NO

X PATIENT SIGNATURE (PARENT OR GUARDIAN) Date

Reviewed by: Doctor Date B.P.

MEDICAL UPDATES

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

Table with 5 columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, B.P., REVIEWED BY. Includes checkboxes for 'None' and 'DR.' for each row.