S. JOEL HEDGECOE, D.D.S.
DAVID J. HEDGECOE, D.D.S.
CHESSICA LOGUE, D.D.S.

PATIENT INFORMATION

❑ MARRIED ❑ SINGLE ❑ WIDOWED ❑ MALE ❑ FEMALE

NAME: _____ EMAIL: _____
TITLE LAST FIRST M

ADDRESS: _____
STREET APT.# CITY STATE ZIP

BIRTHDATE: _____ TELEPHONE: _____ _____ _____
MO DAY YR HOME WORK CELL

PATIENT'S EMPLOYER/SCHOOL: _____ S.S.# _____

SPOUSE OR PARENT NAME: _____ EMPLOYER: _____

Name(s) of household member(s) previously treated in our office: _____

Nearest family member or friend not living with you: Name _____ Phone _____

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

PRIMARY DENTAL INSURANCE

Employee Name: _____
LAST FIRST M

Address: _____
STREET CITY STATE ZIP

Telephone #: _____
HOME # WORK #

Birthdate/ID: _____
MO DAY YR SS# OR ID#

Employer: _____
EMPLOYER

Dental Insurance: _____
INSURANCE CO. NAME GROUP #

ADDRESS PHONE

SECONDARY DENTAL INSURANCE

Employee Name: _____
LAST FIRST M

Address: _____
STREET CITY STATE ZIP

Telephone #: _____
HOME # WORK #

Birthdate/ID: _____
MO DAY YR SS# OR ID#

Employer: _____
EMPLOYER

Dental Insurance: _____
INSURANCE CO. NAME GROUP #

ADDRESS PHONE

MEDICAL AND DENTAL INFORMATION

Are you currently having any dental problems? If yes, please explain _____ YES NO

What would you change about your teeth or your smile? _____

Are you interested in whitening your teeth? _____

Medical Doctor's name _____

Are you under a doctor's care now or have you been during the past two years? Why? _____ YES NO

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

_____

Are you allergic to any medications or substances? What? _____ YES NO

Are you pregnant? (Women) _____ YES NO

Please CIRCLE if you have had any of the following:

Acid Reflux	Cancer	Heart Surgery	Latex Allergy	Sinus Trouble
Allergies	Chemotherapy/Radiation	Hepatitis____	Liver Disease	Sleep Apnea
Artificial Heart Valve	Diabetes	Herpes	Lung Disease	Smoking/Tobacco Use
Artificial Joints/Hips	Drug Addiction	High Blood Pressure	Low Blood Pressure	Stroke
Asthma	Dry Mouth	HIV	Osteoporosis	Thyroid Disease
Blood Disorder	Epilepsy/Seizures	Hypoglycemia	Pain in Jaw Joints	Tuberculosis
Blood Thinner/Aspirin	Heart Murmur/MVP	Kidney Disease	Psychiatric Care	

AUTHORIZATION

I hereby authorize the Dental Office to administer medications and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand that I am responsible for all costs of dental treatment. Payment of insurance benefits directly to the Dental Office is authorized. I understand that any unpaid balance on my account is subject to a service charge which is calculated at a rate of 1.5% every 30 days (annual rate of 18%) based upon any unpaid balance outstanding 90 days or more.

SIGNATURE OF RESPONSIBLE PARTY

X _____ DATE _____

❑ Adult Patient ❑ Father (or Husband) ❑ Mother (or Wife) ❑ Guardian

MEDICAL INFORMATION UPDATES: I have reviewed my medical history and noted any changes.

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____