

**MEDICAL HISTORY**

Home Phone: \_\_\_\_\_

Please use your keyboard and mouse to complete this form. You can then print it out and mail, fax or bring it with you to your next appointment. Our mailing address is Dr. Eleanor Gill, 7271 Goodman Road, Olive Branch, MS 38654. Our fax number is 662.893.3239.

Work Phone: \_\_\_\_\_

Date \_\_\_\_\_ Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient \_\_\_\_\_  
Last Name First Name Initial Preferred Name

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Have you ever had any of the following? (check boxes that apply):

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Heart Problems                    | <input type="checkbox"/> Back Problems                        | <input type="checkbox"/> Chronic Diarrhea               | <input type="checkbox"/> Rheumatic Fever                                       |
| <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Allergies to Anesthetics       | <input type="checkbox"/> Sinus Problems  |
| <input type="checkbox"/> Low Blood Pressure                | <input type="checkbox"/> Respiratory Disease                  | <input type="checkbox"/> Allergies to Medicine or Drugs | <input type="checkbox"/> "A. I. D. S." or Other<br>Immunosuppressive Disorders |
| <input type="checkbox"/> Circulatory Problems              | <input type="checkbox"/> Tuberculosis "TB"                    | <input type="checkbox"/> General Allergies              | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Nervous Problems                  | <input type="checkbox"/> Epilepsy                             | <input type="checkbox"/> Blood Disease                  | <input type="checkbox"/> Ulcer   |
| <input type="checkbox"/> Radiation Treatment               | <input type="checkbox"/> Headaches                            | <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Venereal Disease                                      |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Special Diet                   | <input type="checkbox"/> Chemical Dependence                                   |
| <input type="checkbox"/> Recent Weight Loss                | <input type="checkbox"/> Cancer                               | <input type="checkbox"/> Swollen Neck Glands            | <input type="checkbox"/> Hemophilia  |
| <input type="checkbox"/> Mitral Valve Prolapse             | <input type="checkbox"/> Psychiatric Care                     | <input type="checkbox"/> Asthma                         | <input type="checkbox"/> _____   |
| <input type="checkbox"/> Heart Murmur                      |   |   |  |

Do you have any drug allergies or have you ever had an adverse reaction to any medication?  Yes  No

If so, what? \_\_\_\_\_

Are you allergic to any type of jewelry?  Yes  No \_\_\_\_\_ Are you allergic to nickel or beryllium?  Yes  No

Have you ever responded adversely to medical or dental treatment?  Yes  No \_\_\_\_\_

Are you taking any medication at this time?  Yes  No If so, what? \_\_\_\_\_

Are you under the care of a physician?  Yes  No

For what condition? \_\_\_\_\_

If patient is a child, what is his/her weight? \_\_\_\_\_

(Women) Do you suspect that you are pregnant?  Yes  No Are you nursing?  Yes  No

Have you ever had any type of surgery?  Yes  No If so, please include date. \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If so, what year? \_\_\_\_\_

Is there anything else we should know about your medical history? \_\_\_\_\_

Do you wish to use the nitrous oxide (gas)?  Yes  No

Is there anything you would like to change about your teeth or your smile? \_\_\_\_\_

Are you bothered by bad breath?  Yes  No \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

OFFICE USE ONLY

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date \_\_\_\_\_ Signature \_\_\_\_\_

1) What name do you prefer to be called?  
\_\_\_\_\_

2) Have you ever had a negative experience in a dental office?  
 Yes  No \_\_\_\_\_

3) What is your biggest obstacle to dental care?  
\_\_\_\_\_

4) Are you having any problems with your teeth that we should be aware of?  
\_\_\_\_\_  
\_\_\_\_\_

5) Is it important to you to save your teeth?  
 Yes  No \_\_\_\_\_

6) How do you feel about your smile?  
\_\_\_\_\_  
\_\_\_\_\_

7) Is there anything that you would like to change about your smile if you could?  
\_\_\_\_\_  
\_\_\_\_\_

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Employer \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Home Phone \_\_\_\_\_ Marital Status:  
Work Phone \_\_\_\_\_  Married  Single  
 Divorced  Widowed

**RESPONSIBLE PARTY INFORMATION**

If Self Check Here   
Name \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Home Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Insured Person \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_

**INSURANCE INFORMATION**

(Secondary if Applicable)  
Insured Person \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_

**NAME OF PARENTS (if Child)**

Father \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Mother \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Is Child a Full Time Student? Yes  No   
Where? \_\_\_\_\_

**SPOUSE (if applicable)**

If same as responsible party, check here   
Name \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Home Phone \_\_\_\_\_

**NAME OF NEAREST RELATIVE NOT LIVING WITH YOU**

\_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

**IN CASE OF EMERGENCY, WHO SHOULD WE CALL?**

\_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Whom may we thank for referring you?  
\_\_\_\_\_

## Financial Policy

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

### **Dental Insurance**

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. Our office staff will do everything possible to see that you receive that coverage stated in your policy but you understand that we cannot guarantee how much the insurance coverage will be.

Because the insurance policy is an agreement between you and the insurance company, we ask that each patient be directly responsible for all of his or her own charges. If for some reason your insurance company has not paid their portion **WITHIN 60 DAYS FROM THE START OF TREATMENT, THEN YOU ARE RESPONSIBLE FOR PAYING AT THAT TIME.**

### **Payment Options**

**Cash or Check:** We are happy to offer a 5% discount for payment in full of fees over \$200 at the time of service.

**Credit Cards:** For your convenience, we have made arrangements to accept payment by VISA, Mastercard, or Discover.

**Payment Plans:** Our office is not equipped to carry payment plans for our patients, but

- (1) We have made arrangements with finance companies who offer the option of monthly payments. There are no application fees or down payment and the loan can be interest-free. Applications are available at the front desk and approval is provided quickly.
- (2) We can also provide a payment plan which uses electronic funds transfer on a regular schedule through your bank.
- (3) Another payment plan can be arranged which automatically charges a set amount to your credit card each month.

### **Patient Agreement:**

I understand that payment of this charge is my responsibility and in the event of partial payment or non-payment by my insurance companies, I remain responsible for payment to Eleanor A. Gill, DMD. In the event of litigation I will be responsible for all costs including court costs and attorney's fee.

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Signature

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Date