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? _____

E-mail _____

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.
Balances that are not paid in full at the end of 30 days will be subject to a $5.00 billing fee along 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 _____ **DATE** _____
(FULL NAME) LAST FIRST MIDDLE

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? _____ (Penicillin, Codeine, Latex Rubber, Etc.)	YES	NO
Are you pregnant? (women) _____	YES	NO

Please CIRCLE if you have had any of the following:

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

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 _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

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.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	❒ None _____	_____	DR. _____
_____	_____	❒ None _____	_____	DR. _____
_____	_____	❒ None _____	_____	DR. _____
_____	_____	❒ None _____	_____	DR. _____
_____	_____	❒ None _____	_____	DR. _____
_____	_____	❒ None _____	_____	DR. _____

DENTAL AND MEDICAL HISTORIES – UPDATES