LEGACY DENTAL

1109 South 31st St, Temple, TX 76504 PH: 254-774-8181 FAX: 254-774-8368

Welcome to our office! So that we may provide you with the best possible care, please complete both sides of this form thoroughly. All information will remain confidential.

Patient Name _____
Last First Middle Initial *Preferred Nickname*

Address _____
Street City State Zip

Date of Birth		☐ Male ☐ Female	☐ Single ☐ Married
Social Security #		Driver's License #	State
Home Phone ( )	Work Phone ( )	Cell Phone ( )	Email address
Occupation		Employer	

Spouse's Name	Social Security #
Spouse's Date of Birth	Work Phone ( )
Employer	Occupation

Person responsible for payment: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other
If responsible party is not yourself or your spouse, please complete this section:

Name _____ Home Phone ( )_____

Address, including street, city, state and zip: _____

DENTAL INSURANCE	
Insurance Company Name	Group #
Insured's Name	Employee # (if different than SS#)

Please read, and then initial.
Your dental insurance policy is an arrangement between the insurance carrier and you. Our office is happy to prepare claim forms to assist you in making collection from the insurance carrier. Any amount authorized to be paid directly to the dentist will be credited to your account upon receipt. Payment of your account is your responsibility, and you will be asked to pay in full for balances or uncovered procedures.

_____Initial here to signify understanding and agreement

Whom can we thank for referring you? _____

Have you received dental services from this office or Dr. Megens before? ☐ **YES** ☐ **NO**; When? _____

Is an immediate family member a patient here? ☐ **YES** ☐ **NO**; Who? _____

Contact in case of emergency: Name:	
Relationship to Patient	Phone ( )

MEDICAL HEALTH HISTORY

1. Are you currently under a physicians care? ☐ **YES** ☐ **NO.** Dr.'s Name: _____

Phone #: ( ) _____ Reason for medical treatment: _____

2. Are you taking any medications, drugs or vitamin/food supplements? ☐ **YES** ☐ **NO**

If yes, what? _____

3. Have you been seriously ill or hospitalized during the past five years? ☐ **YES** ☐ **NO**

If yes, why? _____

4. Are you aware of having allergic or adverse reactions to any medications, substances, anesthetics or metals?

☐ **YES** ☐ **NO** Penicillin / Codeine / Latex / Other: _____

5. Please indicate which of the following you have had, or have at present, or never had any of the following:

Y	N		Y	N		Y	N	
☐	☐	Chest pain/angina	☐	☐	Stroke	☐	☐	Ulcers
☐	☐	Heart attack/disease/surgery	☐	☐	Fainting or dizzy spells	☐	☐	Venereal disease
☐	☐	Heart murmur	☐	☐	Neurological disorders	☐	☐	AIDS
☐	☐	Congenital heart disease	☐	☐	Epilepsy or seizures	☐	☐	HIV positive
☐	☐	Heart pacemaker	☐	☐	Nervous/Anxiety disorder	☐	☐	Bisphosphonate meds
☐	☐	Artificial heart valve	☐	☐	Psychiatric care	☐	☐	Osteoporosis
☐	☐	Swollen ankles	☐	☐	Immune system issues	☐	☐	Radiation/Chemotherapy
☐	☐	Arthritis/Rheumatic fever	☐	☐	Hay fever	☐	☐	Tumors
☐	☐	Cortisone medication	☐	☐	Sinus trouble	☐	☐	Thyroid: Hypo / Hyper
☐	☐	High blood pressure	☐	☐	Allergies or hives	☐	☐	Diabetes: A1C# >5 6 7 8 9 10<
☐	☐	Anti-coagulant/platelet meds	☐	☐	Chronic cough	☐	☐	Glaucoma
☐	☐	Blood transfusion	☐	☐	Asthma	☐	☐	Contact lenses
☐	☐	Hemophilia	☐	☐	Emphysema	☐	☐	Cold sores
☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney trouble
☐	☐	Yellow jaundice	☐	☐	Bruise easily	☐	☐	Dip / Smoke: Years _____
☐	☐	Liver disease	☐	☐	Hepatitis: B / C	☐	☐	Artificial Joint: L / R _____

Doctor's Notes:_____

_____

6. Do you have any problem, disease or condition not listed above? ☐ **YES** ☐ **NO.**

If Yes, describe: _____

7. Have you lost or gained 10 or more pounds in the last year? ☐ **YES** ☐ **NO.** Reason: _____

8. Female patients: Are you pregnant? ☐ **YES** (_____ mths) ☐ **NO.** Are you Nursing? ☐ **YES** ☐ **NO.**

Attempting to conceive? ☐ **YES** ☐ **NO**

CONSENT FOR TREATMENT

I understand the information on this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify Dr. Megens of any changes in my health or medication. I give authorization to take x-rays, study models, photographs, or any other diagnostic aids needed to make a thorough diagnosis of my dental needs, or the minor patient's needs. I give authorization for Dr. Megens to perform any and all forms of treatment, medication and therapy that may be indicated in treatment of said patient. I further give authorization to choose and employ such assistance as deemed fit.

I understand responsibility for payment of dental services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless other financial arrangements have been *previously* made.

PATIENT (or Guardian) Signature _____ Date _____

Dentist Signature _____ Date _____