Batesville Dentistry

310 Highway 51 South | Batesville, MS 38606 | 662-563-9550

Patient's Name_______________________________
Birthday___/___/_____ **SS #**___________________

Phone: **Home**______________ **Cell**_______________
Work_______________ Alt_______________

Mailing Address________________________________
City______________ State________ Zip____________
911 Address_____________________________________
(IF DIFFERENT FROM MAILING ADDRESS)

If Child, Parent's Name_________________________
Parent's SS# __________________________________

Patient Email___________________________________
Patient/ Parent Employed by___________________
Present Position____________ How long__________
Spouse/Parent Name__________________________
Spouse Employed By___________________________
Present Position____________ How long__________

Medical Information

Primary Physician_____________________________
Are you taking any medications?________________
LIST ALL_______________________________________
____
____
Are you allergic to any medications/foods? ______
Please List____________________________________
____
Have you been hospitalized in the last 2 yrs?______
Why?____
____

Dental Information

When was your last dental visit? _______________
What was done at that time?___________________
Do you have a problem or complaint at this time?
____
____

We appreciate all referrals! Who may we thank for referring you? Or how did you hear about our office? _____________________________________

Emergency Contact:

Name____
Phone____

Dental Insurance

Employee Name________________________________
Employee DOB_____________SS#_________________
Insurance Comp.________________________________
Phone#___________________ Group#____________

Do you have, Or have ever had?	**Please Circle**	
Heart Murmur	YES	NO
Fainting Spells	YES	NO
Heart Condition*	YES	NO
Malignancy	YES	NO
Abnormal Blood Pressure	YES	NO
Tuberculosis	YES	NO
Abnormal Bleeding	YES	NO
Tested Positive for HIV	YES	NO
Anemia	YES	NO
Radiation Therapy	YES	NO
Diabetes	YES	NO
Venereal Disease	YES	NO
Epilepsy/Seizure	YES	NO
Hepatitis	YES	NO
Asthma	YES	NO
Rheumatic Fever	YES	NO
Aspirin Regimen*	YES	NO
Blood Thinners*	YES	NO
Any Joint Replacements*	YES	NO
Bone Preservation Treatment*	YES	NO
Bone Cancer	YES	NO
Mitral Valve Prolapse	YES	NO
Might you be Pregnant*	YES	NO

(If you marked yes on any *remarks, Please let us know prior to the appointment.)

Comments___________________________________

Patient's or Guardian's Signature ____________________________________Date__________