Snake River Periodontics & Implant Dentistry
Duke Davis, DMD, PLLC

Date:_____

Patient Name:_____
Birthdate:_____

Patient SS#_____ Male / Female Single / Married

Mailing
Address:_____
____

City:_____ State:_____ Zip Code:
_____

Home Phone #_____ Cell #_____ Work
#_____

Email:_____ Name of Parent/Guardian
_____

DENTAL INSURANCE INFORMATION ***PRIMARY INSURANCE***

Subscriber Name:_____
Birthdate:_____
Address:_____City:_____State:_____Zi
p:_____

SS#_____ Insurance
Company:_____

ID #_____ Group #_____

SECONDARY INSURANCE

Subscriber Name:_____
Birthdate:_____

Address:_____City:_____State:_____Zi
p:_____

SS#_____ Insurance
Company:_____

ID #_____ Group #_____

I verify the above information is correct to the best of my knowledge. I understand and acknowledge that I am financially responsible for the service provided for myself of the above named patient regardless of insurance coverage. If the amount is assigned for collection, I agree to pay all attorney fees, court costs, and other reasonable collection charges or commissions, which may result from pursuing the collection of this account.

I also understand that dental insurance may not fully cover the services provided. I will authorize information to be furnished to the insurance carriers and assign all payment for services rendered to my attending doctor. I further understand that insurance claims will be submitted as a courtesy service.

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics by my attending dentist or by his supervised staff for myself or the above named patient.

Signature:_____Date:_____

I,_____ acknowledged that I have had the opportunity to read and request a copy of the current Dr. Jason M. Peterson Notice of Privacy Practices.

Signature:_____Date:_____

Health Information

General Dentist:_____ Personal Physician:_____

List of medications you are taking:_____

_____

_____

Are you allergic to any medications or antibiotics? Yes / No

List any allergies:_____

___

Circle any of the following conditions you have:

Heart Attack	Osteoporosis	Artificial Joints (any)	Fainting
Chest Pain	Ulcers	Colitis	Thyroid Disease
Heart Defects	Liver Disease	Glaucoma	Cancer
Rheumatic Fever	Heart Murmur	Aids/HIV	Radiation/Chemo Therapy
Artificial Heart Valve	Abnormal Bleeding	Sinusitis	Tuberculosis
Stroke	Asthma	Emphysema	Seizures
High Blood Pressure	Diabetes	Hepatitis	Psychiatric Disorder
Mitral Valve Prolapse			

Have you taken any medication to treat osteoporosis? Yes / No

Do you smoke? Yes / No If so, how much per day?_____

Dental History

Please list what concerns you have regarding your mouth:_____

_____

_____

How frequent are you receiving dental cleanings?_____

Circle any of the following that apply:

Jaw Joint Discomfort	Clenching or Grinding	Orthodontic Treatment
Loose/Missing Teeth	Sensitive Teeth	Dry Mouth
Bad Breath	Poor Fitting Denture	Poor Fitting Partial Denture
Dental Phobia	Fear of Treatment	Aesthetic Concerns

Other:_____

_____