GARDEN HOME DENTAL

Patient Name ____

Address ____

City ______________________ State _______________________ Zip ________________________

Date of Birth: _________________ Social Security # ____________________________________

Sex: Male ☐ Female ☐ Married ☐ Single ☐ Child ☐

Phone _____________________ Work ________________________ Cell _____________________

Email ____

Who may we thank for referring you? ____

Primary Dental Insurance/Responsible Party

(please complete if someone other than the patient is responsible for the charges)

Dental Insurance Subscriber _____________________________________ DOB ________________

Relation to Patient ____________________ Social Security # _____________________________

Address (if different than patient) ____

City ______________________ State _______________________ Zip ________________________

Insurance Company _____________________________________ ID # _______________________

Group # _____________________________ Insurance Phone # ____________________________

Additional Dental Insurance

Is patient covered by other insurance? Yes ☐ No ☐

Dental Insurance Subscriber _____________________________________ DOB ________________

Relation to Patient ____________________ Social Security # _____________________________

Address (if different than patient) ____

City ______________________ State _______________________ Zip ________________________

Insurance Company _____________________________________ ID # _______________________

Group # _____________________________ Insurance Phone # ____________________________

Dental History

Former Dentist ________________________ Last Visit ___________ Last X-rays _____________

Medical History

Physician's Name _______________________________ Date of last exam __________________

Have you had any serious illness or operations? Yes ☐ No ☐ Blood Transfusion? Yes ☐ No ☐

If yes, please describe ____

Check box if you have ever taken: ☐ "fen-phen" ☐ Fosomax ☐ Zomata ☐ Boniva

(Women) Are you pregnant? Yes ☐ No ☐ Nursing Yes ☐ No ☐ Taking birth control Yes ☐ No ☐

Check box if you have or have had any of the following:

☐ Anemia	☐ Diabetes	☐ Jaw Pain	☐ Scarlet Fever
☐ Arthritis	☐ Epilepsy	☐ Kidney Disease	☐ Shortness of breath
☐ Asthma	☐ Fainting	☐ Latex Allergy	☐ Spina Bifida
☐ Artificial Joints	☐ Glaucoma	☐ Liver Disease	☐ Stroke
☐ Back Problems	☐ Headaches	☐ Low Blood Pressure	☐ Surgical Implant
☐ Blood Disease	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Cancer	☐ Heart Problems	☐ Pacemaker	☐ Tobacco Habit
☐ Chemical Dependency	☐ Hemophilia	☐ Persistent Cough	☐ Tonsillitis
☐ Chemotherapy	☐ Hepatitis	☐ Radiation Treatment	☐ Ulcer/Colitis
☐ Circulatory Problems	☐ High Blood Pressure	☐ Respiratory Problems	☐ Venereal Disease
☐ Cortisone Treatments	☐ HIV/AIDS	☐ Rheumatic Fever	

Medications ____

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Allergies ____

Authorization

The information I have provided is accurate and complete to the best of my knowledge. I understand it will be used for my treatment, billing and processing of my insurance benefits for which I am entitled. I certify all insurance benefits to be paid directly to Dr. Aaron Pogue for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. In the event that payment in full is not made and requires a collection agency for charges incurred, I agree to pay all cost of collections including a collection fee of $75.00, attorney fees, court costs and interest at the rate of 1.5% per month (18% per annum).

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Signature of Patient, Guardian, or Personal Representative Date

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Please Print Name of Patient, Guardian, or Personal Representative Date