DAVIS & DINGLE
FAMILY DENTISTRY

MEDICAL HISTORY UPDATE

3026 FARROW ROAD
COLUMBIA, SC 29203
WWW.DAVISANDDINGLE.COM

PATIENT INFORMATION

PATIENTS NAME: LAST_______________________________ FIRST_______________________________ MI_________

GENDER (CHECK ONE)**:** FEMALE MALE

MARITAL STATUS (CHECK ONE)**:** MARRIED SINGLE CHILD OTHER

BIRTHDATE:_______________________ **SOCIAL SECURITY NUMBER:**_______________________

ADDRESS: STREET____ APT#_____________

CITY_________________________________ STATE:____________ ZIP:____________

EMAIL ADDRESS:____

PHONE:(HOME) __________________ (WORK) __________________ EXT:_____ BEST TIME TO CALL:________

(CELL) __________________

INSURANCE INFORMATION

EMPLOYER:___________________ **INSURANCE:**__________________ **INSURANCE COMPANY#:**_______________

SUBID#:__________________ **PHONE:**____________________ **GROUP#:**______________________

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____

HEALTH INFORMATION

AIDS/HIV
ALLERGIES
____
BLOOD THINNER
ANEMIA
ARTHRITIS
ARTIFICIAL JOINTS D ASTHMA
BLOOD DISEASE D CANCER
DIABETES
DIZZINESS
EXCESSIVE BLEEDING
FAINTING
GLAUCOMA
GROWTHS

HAY FEVER
HEAD INJURIES
HEART DISEASE
HEART MURMUR
HEPATITIS
HIGH BLOOD PRESSURE
JAUNDICE
KIDNEY DISEASE
LIVER DISEASE
MENTAL DISORDERS
PACEMAKER
CURRENTLY PREGNANT:
DUE DATE ___________
RADIATION TREATMENT

RESPIRATORY PROBLEMS
RHEUMATIC FEVER
RHEUMATISM
SINUS PROBLEMS
STOMACH PROBLEMS
STROKE
TUBERCULOSIS
TUMORS
ULCERS
VENEREAL DISEASE
CODEINE ALLERGY
PENICILLIN ALLERGY
OTHER:
____

To the best of my knowledge, all the preceding answers and information are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ ________________________________

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

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MISSED APPOINTMENT POLICY

We are delighted you have chosen Davis and Dingle Family Dentistry to provide you and/or your family's dental care and we want to ensure that you are getting the best care possible. This is why it is so important to keep your scheduled appointments.

Effective December 2016, our missed appointment fee is $50.00. This fee is not covered by insurance.

A missed appointment is when you fail to show up for a scheduled appointment or when you fail to notify us of the cancellation with less than 48 hours' notice. When you miss your appointment, you compromise your care, and prevent other patients from being seen who are waiting for an open appointment.

The doctor/patient relationship is built on mutual trust and respect. As a courtesy, we make every effort to contact you 2 weeks to 48 hours prior to your scheduled appointment time. We ask that you call (803) 255-0200, and speak with one of our staff members, or send an e-mail to, customerservice@ davisanddingle.com.

We appreciate your understanding of the need for this policy.

______________________________ ______________________________

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

PHOTOGRAPHY CONSENT FORM/RELEASE

I, (print name) ______________________________, hereby grant permission to Davis and Dingle Family Dentistry and its representatives, to take and use: photographs, audio and video recording and/or digital images of me for advertisements and duplication in marketing materials. These materials might include printed or electronic publications, website and other social media outlets.

I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I AUTHORIZE the use of these images without compensation to me. All negatives, digital reproductions, audio/video master shall be the property of Davis and Dingle Family Dentistry.

I further agree to hold Davis and Dingle Family Dentistry and its representatives harmless from all claims arising from the use of said photographs, audio and video recordings and/or digital images of me when used within the scope described above.

______________________________ ______________________________

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE