Garrett D. Toy, DDS

General and Hospital Dentistry

PATIENT INFORMATION

Date:_____/_____/_____

Last:_____ First:_____ MI___ Preferred: _____

Gender: M F Marital Status:_____ Birth Date:____/____/____ Age____ Social Security:_____-_____-_____

Address:_____ City:_____ State:____ Zip: _____

Home Phone: (_____)_____ Cell: (_____)_____ Fax: (_____)_____

Driver's License No.:_____ Occupation:_____

Employer:_____ Work Phone: (_____) _____

If Student, School:_____ Grade:_____ Units:_____

Person to contact for emergency:_____ Phone: (_____) _____

Physician:_____ Phone: (_____) _____

Who may we thank for referring you?: _____

SPOUSE/PARENT/GUARDIAN INFORMATION

Name:_____ Relationship to Patient: _____

Address:_____ City:_____ State:____ Zip: _____

DOB:_____/_____/ _____ Social Security No:_____-_____-_____ Home Phone: (_____) _____

Employer:_____ Work Phone: (_____) _____

FACILITY INFORMATION

Facility Name:_____ Contact Person: _____

Address:_____ City:_____ State:____ Zip: _____

Phone: (_____)_____ Cell: (_____)_____ Fax: (_____)_____

TCRC Case Worker:_____ Phone: (_____) _____

INSURANCE INFORMATION

Primary Insurance:_____ Phone: (_____) _____

Insured's Name_____ DOB:____/____/____ SS#:_____-_____-_____ Group No.: _____

Address:_____ City:_____ State:____ Zip:_____

Employer:_____ Work No: (_____) _____

Patient's relationship to insured: Self____ Spouse____ Child____ Other____

Secondary Insurance:_____ Phone: (_____) _____

Insured's Name_____ DOB:____/____/____ SS#:_____-_____-_____ Group No.: _____

Address:_____ City:_____ State:____ Zip:_____

Employer:_____ Work No: (_____) _____

Patient's relationship to insured: Self____ Spouse____ Child____ Other____

MEDICAL HISTORY

All answers will be held in strict confidentiality

Do you have any medical conditions, if yes, please explain: (example: C.P. Autism) _____

_____

Please list any medicines you are taking: _____

_____

Pharmacy: _____ City: _____

☐ No Known Drug Allergies or

Are you allergic or have adverse reactions to:

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Ibuprofen ☐ Latex

☐ Local Anesthetics ☐ Penicillin ☐ Sulfa ☐ Other _____

Women: Are you pregnant? ☐ Yes ____ Mos. ☐ No Nursing? ☐ Yes ☐ No Birth Control Pills? ☐ Yes ☐ No

Have you had any of the following conditions:

Stroke	Yes	No	Hay fever	Yes	No	Transfusions	Yes	No
Heart attack	Yes	No	Tuberculosis	Yes	No	Hemophilia	Yes	No
Congenital heart disease	Yes	No	Chronic cough	Yes	No	Bruise easily	Yes	No
High blood pressure	Yes	No	Fen-Phen/ diet pill	Yes	No	Arthritis/ rheumatism	Yes	No
Pacemaker	Yes	No	Significant weight change	Yes	No	Venereal disease	Yes	No
Artificial heart valve	Yes	No	Headaches	Yes	No	HIV/AIDS	Yes	No
Artificial Joints (knee, hip)	Yes	No	Fainting/dizziness	Yes	No	Alcohol/ drug abuse	Yes	No
Rheumatic/scarlet fever	Yes	No	Psychiatric care	Yes	No	Liver disease	Yes	No
Heart murmur	Yes	No	Hearing disorders	Yes	No	Hepatitis	Yes	No
Chest pain	Yes	No	Speech disorders	Yes	No	Jaundice	Yes	No
Paralysis	Yes	No	Cold/fever blisters	Yes	No	Cancer	Yes	No
Epilepsy/seizures	Yes	No	Thyroid disease	Yes	No	Chemotherapy	Yes	No
Asthma	Yes	No	Kidney disease	Yes	No	Radiation therapy	Yes	No
Sinus infection	Yes	No	Diabetes	Yes	No	Recent Hospitalizations	Yes	No

I understand that the personal, financial, and medical information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. If I ever have any changes in the information provided, I will inform the doctor and/or staff at my next appointment. I also authorize and consent to x-rays, study models, photographs, medications and/or any other diagnostic aids for treatment and diagnosis.

Patient, Parent, or Responsible Party's Signature: _____ Date: _____

I request that payment of authroized insurance benefits be made either to Dr. Toy on my behalf or to myself for any services rendered to me by him. I understand that I am responsible for all charges incurred regardless of insurance coverage.

Signed: _____ Date: _____

I acknowledge that I am responsible for all charges incurred if my insurance company determines that I was not eligible at the time services were rendered or that the services were not a covered benefit regardless of whether I have an insurance authroization for the services.

Signed: _____ Date: _____

I authorize Dr. Toy to release any medical information or any other information necessary to process my insurance claim for serivces rendered by Dr. Toy.

Signed: _____ Date: _____ Witness: _____