JOHN S. WINFORD, D.D.S., P.C.
3980 New Covington Pike, Suite 306
Memphis, TN 38128
Phone: (901) 382-2887

INFORMATION ABOUT THE PATIENT

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	BIRTHDAY	AGE

RESIDENCE ADDRESS	CITY	STATE	ZIP	RESIDENCE TELEPHONE

EMPLOYER'S NAME & ADDRESS	CITY	STATE	ZIP	BUS/CELL PHONE

RELATIONSHIP OR PATIENT TO RESPONSIBLE PARTY	OCCUPATION
☐ Self ☐ Wife ☐ Husband ☐ Child ☐ Other _____	

NAME OF PHYSICIAN PHARMACY PHONE #	PHYSICIAN'S ADDRESS	CITY	STATE	ZIP	PHYSICIAN'S TELEPHONE

DENTAL INSURANCE COMPANY	ADDRESS	PHONE	REFERRING DENTIST

SUBSCRIBER'S NAME	SUBSCRIBER ID #	GROUP NO.	PLACE OF BUSINESS

RESPONSIBLE PARTY INFORMATION (if minor)

NAME	SOCIAL SECURITY NUMBER	BIRTH DATE

HOME ADDRESS	CITY	STATE	ZIP	HOME TELEPHONE NUMBER

NAME OF EMPLOYER	PRESENT POSITION	HOW LONG EMPLOYED

BUSINESS ADDRESS	CITY	STATE	ZIP	BUSINESS TELEPHONE NUMBER

DENTAL INSURANCE COMPANY	SUBSCRIBER ID #	PHONE	GROUP NUMBER

INSURER'S ADDRESS	CITY	STATE	ZIP

SPOUSE OR EMERGENCY CONTACT INFORMATION

NAME	SOCIAL SECURITY NUMBER	BIRTH DATE

HOME ADDRESS	CITY	STATE	ZIP	HOME TELEPHONE NUMBER

NAME OF EMPLOYER	PRESENT POSITION	HOW LONG EMPLOYED

BUSINESS ADDRESS	CITY	STATE	ZIP	BUSINESS TELEPHONE NUMBER

DENTAL INSURANCE COMPANY	SUBSCRIBER ID #	PHONE	GROUP NUMBER

INSURER'S ADDRESS	CITY	STATE	ZIP

CONSENT TO TREATMENT

Date _____

I was informed by the above named doctor(s) of the risks, possible alternative methods of treatment and possible consequences involved in the treatment by means of : General Exams, Cleanings & X-rays.

Understanding this, I hereby authorize the above named doctor(s) or whomever s/he (they) may designate, to administer treatment to me (or _____)
Name of Patient if Minor

Signed _____ Date _____
Patient or Person Authorized to Consent for Patient

Witness _____ Date _____

MEDICAL HISTORY

Please describe your present health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has your present health changed in the last year? _____

Have you been hospitalized for illness or surgery? _____

Has a doctor treated you for any condition in the last two years? _____

Are you allergic to any drugs or other substances? _____

Have you ever experience bleeding that was difficult to stop? _____

Has anyone in your family ever had diabetes? _____

Are you taking any medications (even aspirin, vitamins, hormones, or antacids)? If so please list them with dosages: _____

_____

_____

PLEASE INDICATE YES OR NO FOR ANY CONDITIONS EVEN IF YOU NO LONGER HAVE THEM

□ Yes □ No Heart Trouble	□ Yes □ No Weight Reduction Medication: such as Phen Fen/Redux	□ Yes □ No Often Fatigued
□ Yes □ No Heart Murmur		□ Yes □ No Nervous/Anxious
□ Yes □ No Heart Surgery		□ Yes □ No Frequent Headaches
□ Yes □ No Rheumatic/Scarlett Fever	□ Yes □ No Hepatitis A,B,C	□ Yes □ No Depression
□ Yes □ No Congenital Heart/ Lesions/Defects	□ Yes □ No Liver Disease/Jaundice	□ Yes □ No Weight Changes
	□ Yes □ No Diabetes I or II	□ Yes □ No Sinus Trouble
□ Yes □ No Heart Pacemaker	□ Yes □ No Kidney Disease/Dialysis	□ Yes □ No Artificial Joints
□ Yes □ No Valve Replacement	□ Yes □ No Asthma	□ Yes □ No Swollen Lymph Glands
□ Yes □ No Heart Attack/Stents/Bypass	□ Yes □ No Lung Disease	□ Yes □ No Dry Mouth
□ Yes □ No High/Low Blood Pressure	□ Yes □ No Bronchitis	□ Yes □ No AIDS/ARC/HIV
□ Yes □ No Mitral Valve Prolapse	□ Yes □ No Emphysema	□ Yes □ No Anemia/Blood Disease Hemopilia
□ Yes □ No Hardening of Arteries	□ Yes □ No Epilepsy	
□ Yes □ No Shortness of Breath	□ Yes □ No Fainting	□ Yes □ No Psychiatric Care
□ Yes □ No Chest Pains	□ Yes □ No Ulcers	□ Yes □ No STD's
□ Yes □ No Blood Thinners	□ Yes □ No Stroke	□ Yes □ No Smoke or use Tobacco in any form
□ Yes □ No Hives/Rash	□ Yes □ No Arthritis	□ Yes □ No Anesthetic reactions (local, general or sedation)
□ Yes □ No Hay Fever	□ Yes □ No Glaucoma	
□ Yes □ No Infections	□ Yes □ No Tumors/Cancer	□ Yes □ No Osteoporosis
□ Yes □ No Parathyroid Disease/ Thyroid Disease	□ Yes □ No Chemo/Radiation	□ Yes □ No Osteoporosis medication: such as Fosomax, Boniva, etc.
	□ Yes □ No Often Thirsty	
□ Yes □ No Alcohol Habits	□ Yes □ No Frequent Urination	□ Yes □ No Antibiotics Prior to Dental Procedure

If Female Are You: ☐ Pregnant ☐ On Birth Control ☐ In or Past Menopause?

IS THERE ANY CONDITION OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT? _____

_____

_____Height_____Weight_____

COMMENTS: _____

In order to control our costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing cost than be forced to raise our fees.

My payment will be made for services rendered by: (Please check one)

☐ CASH ☐ CHECK ☐ MASTER CARD ☐ VISA(OR) ☐ AMERICAN EXPRESS

PLEASE NOTE: There will be a $30.00 charge for returned checks. Without 48 hr. (2 business days) cancellation notice, there will be a $50.00 fee for cleaning appointments or a $100.00 fee for each hour of surgery scheduled.

☐ Previous arrangements made and approved by _____.

AUTHORIZATION

I hereby authorize John S. Winford, D.D.S., P.C. to furnish information to insurance carriers concerning my treatment and I hereby irrevocably assign to them all insurance benefits otherwise payable to me. I understand that I am financially responsible for payment of all charges not covered by this authorization within 30 days, whether or not paid by insurance. I also understand that I am responsible for reasonable collection costs and/or attorney fees incurred for collection of this account. I hereby authorize release of any information acquired in the course of my examination or treatment. A photocopy of this statement is to be considered as valid as an original.

_____ _____ _____

PATIENT'S SIGNATURE (Or Parent or Guardian if Patient is a minor) DATE REVIEWED BY

Please Complete Other Side