MICHAEL C. PARKEY, D.D.S. CRAIG T. DAVIS JR., D.D.S.
906 ENTERPRISE DRIVE • JONESBORO, AR 72401

Patient Information

Date ______________________________

Patient's Name ______________________________
Last First Middle

Address ______________________________
Street City State Zip

Home Phone ____________ Birthdate ____________ Social Security # ____________

Preferred Pharmacy ____________ Email Address ____________

If patient is a minor, give parent's or guardian's name ____________

Whom may we thank for referring you to our office? ____________

Responsible Party Information

Name ____________ Relationship to Patient ____________
Last First Middle

Residence ______________________________
Street City State Zip

Mailing Address if Different ______________________________
Street City State Zip

How Long at this Address? ____________ Previous Address (if less than 3 yrs.) ____________
Street City State Zip

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Social Security # ____________ Birthdate ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

Spouse's Name ____________ Relationship to Patient ____________
Last First Middle

Spouse's Work Phone ____________ Cell Phone ____________ Social Security # ____________ Birthdate ____________

Spouse's Employer ____________ Occupation ____________ No. Years Employed ____________

I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICE AND MATERIALS NOT PAID BY MY DENTAL BENEFIT PLAN, UNLESS THE TREATING DENTIST OR DENTAL PRACTICE HAS A CONTRACTUAL AGREEMENT WITH MY PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES TO THE EXTENT PERMITTED UNDER THE APPLICABLE LAW. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THE CLAIM.

• RESPONSIBLE PARTY'S SIGNATURE ____________ **DATE** ____________

Dental Insurance Information

Insured's Name ____________ Marital Status ____________
Last First Middle

Insurance Company ____________ Group # ____________ Local # ____________

Insurance Company Address ______________________________
Street City State Zip

I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTAL ENTITY

• INSURED'S SIGNATURE ____________ **DATE** ____________

Do you have dual coverage? Yes ❐ No ❐ If yes: ____________

Insured's Name ____________ Marital Status ____________
Last First Middle

Insurance Company ____________ Group # ____________ Local # ____________

Insurance Company Address ______________________________
Street City State Zip

I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTAL ENTITY

• INSURED'S SIGNATURE ____________ **DATE** ____________

Emergency Information

Name of nearest relative not living with you ____________

Residence ____________ Phone ____________
Street City State Zip

Sex: Circle One

Male
Female

If female, please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

******PLEASE NOTE******
ANTIBIOTIC MEDICATIONS PRESCRIBED BY THE DENTIST FOR INFECTION CAN REDUCE THE EFFECTIVENESS OF YOUR BIRTH CONTROL MEDICATION!

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Glaucoma	☐	☐	Sinus Problems
☐	☐	Alcohol Abuse	☐	☐	Hay Fever	☐	☐	Stroke
☐	☐	Allergies	☐	☐	Heart Attack	☐	☐	Thyroid Problems
☐	☐	Anemia	☐	☐	Heart Murmur	☐	☐	Tuberculosis
☐	☐	Angina Pectoris	☐	☐	Heart Surgery	☐	☐	Ulcers
☐	☐	Arthritis	☐	☐	Hemophilia	☐	☐	Venereal Disease
☐	☐	Artificial Bones or Joints	☐	☐	Hepatitis A	☐	☐	Yellow Jaundice
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis B			
☐	☐	Asthma	☐	☐	High Blood Pressure			
☐	☐	Blood Transfusion	☐	☐	HIV & AIDS			
☐	☐	Cancer - Chemotherapy	☐	☐	Kidney Problems			
☐	☐	Colitis	☐	☐	Liver Disease			
☐	☐	Congenital Heart Defect	☐	☐	Low Blood Pressure			
☐	☐	Cosmetic Surgery	☐	☐	Mitral Valve Prolapse			
☐	☐	Diabetes	☐	☐	Pneumocystitis			
☐	☐	Difficulty Breathing	☐	☐	Psychiatric Problems			
☐	☐	Drug Abuse	☐	☐	Radiation Therapy			
☐	☐	Emphysema	☐	☐	Rheumatic Fever			
☐	☐	Fainting Spells	☐	☐	Seizures			
☐	☐	Fever Blisters	☐	☐	Shingles			
☐	☐	Frequent Headaches	☐	☐	Sickle Cell Disease			

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	Tetracycline

Other: ____________________

____

Have you been hospitalized in the last 5 years? YES or NO
If yes, please explain ____________________

____

Have you had any operations in the last 5 years? YES or NO
If yes, please explain ____________________

____

Have you ever tested positive for HIV or AIDS? YES or NO

Are you allergic to any Local Anesthetics ? YES or NO
If yes, please list ____________________

Are you taking ANY medications? YES or NO
If yes, please list ____________________

____

____

Have you or do you currently use illicit or recreational drugs?
(I.E. marijuana, cocaine, amphetamines, crack, crystal meth, etc.) YES or NO
Please specify ____________________

Do you smoke or use any tobacco products? YES or NO

Do you require antibiotics before dental treatment? YES or NO

What is the name of your medical physician? ____________________

Who was your previous dentist? ____________________

Date of last visit? (Approximate) ____________________

Are you interested in keeping your natural teeth for the rest of your life? YES or NO

Are you unhappy with the color of your teeth? YES or NO

Do you have discomfort in your jaw joint? YES or NO

Do you catch food between your teeth? YES or NO

Do your gums bleed? YES or NO

Do you have persistent bad breath? YES or NO

Are you having any problems with your teeth? YES or NO
If yes, please explain ____________________

____

Would you like to change anything about your smile? YES or NO
(I.E. whitening, straightening, lengthening, or white fillings etc.....)
If yes, please explain ____________________

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I CERTIFY THAT I CAN READ AND UNDERSTAND THE ABOVE INFORMATION. I WILL NOT HOLD DR. PARKEY, DR. DAVIS OR ANY MEMBERS OF THEIR STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM. I CONSENT TO RECEIVING LOCAL ANESTHESIA (TO BE NUMBED) FOR ANY INDICATED DENTAL TREATMENT. I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

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SIGNATURE OF PATIENT
IF MINOR, SIGNATURE OF PARENT OR GUARDIAN