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

Responsible Party Information

Name ______ Last ______ First ______ Middle ______ Marital Status ______

Residence ______ Street ______ City ______ State ______ Zip ______ ☐ Own ☐ Rent

Mailing Address ______ Street ______ City ______ State ______ Zip ______ Email ______

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

Primary Phone ______ Work Phone ______

Social Security # ______ Birth date ______ Relationship to Patient ______

Employer ______ Occupation ______ No. Years Employed ______

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

Employer ______ Occupation ______ No. Years Employed ______

Social Security # ______ Birth date ______ Work Phone ______

Confidential Patient Information (if different from above)

Patient's Name ______ Last ______ First ______ Middle ______

Address ______ Street ______ City ______ State ______ Zip ______

Home Phone ______ Birth date ______ Social Security # ______

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

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

Emergency Information

Name of nearest relative not living with you ______

Complete Address ______

Phone ______ Relationship ______

Insurance Information

Policy Holder's Name ______ Social Security # ______

Insurance Company ______ Group No. ______

Insurance Co. Address ______ Insurance Co. Phone ______

Policy Holder's Employer ______

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name ______ Social Security # ______

Insurance Company ______ Group No. ______

Insurance Co. Address ______ Insurance Co. Phone ______

Policy Holder's Employer ______

I agree to be responsible for all charges for dental service and materials not paid for by my dental benefits plan. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. 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.

______

Signature of Patient (if minor, signature of parent or guardian) Date

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!

Do you have, or have you had any of the following?

	Y	N
Abnormal Bleeding	☐	☐
Alcohol Abuse	☐	☐
AIDS/HIV Positive	☐	☐
Alzheimer's Disease	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis/Gout	☐	☐
Artificial Heart Valve	☐	☐
Artificial Bones or Joints	☐	☐
Asthma	☐	☐
Blood Disease	☐	☐
Blood Transfusion	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chemotherapy	☐	☐
Colitis	☐	☐
Congenital Heart Disorder	☐	☐
COPD	☐	☐
Cosmetic Surgery	☐	☐
Convulsions	☐	☐
Diabetes	☐	☐
Difficulty Breathing	☐	☐
Drug Addiction	☐	☐
Emphysema	☐	☐

	Y	N
Epilepsy or Seizures	☐	☐
Fainting Spells/Dizziness	☐	☐
Fever Blisters	☐	☐
Frequent Headaches	☐	☐
Glaucoma	☐	☐
Hay Fever	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Heart Pacemaker	☐	☐
Heart Surgery	☐	☐
Hemophilia	☐	☐
Hepatitis A	☐	☐
Hepatitis B or C	☐	☐
High Blood Pressure	☐	☐
Irregular Heart Beat	☐	☐
Kidney Problems	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Lung Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Osteoporosis	☐	☐
Pain in Jaw Joints	☐	☐
Psychiatric Problems	☐	☐
Radiation Therapy	☐	☐
Recent Weight Loss	☐	☐

	Y	N
Renal Dialysis	☐	☐
Rheumatic Fever	☐	☐
Shingles	☐	☐
Sickle Cell Disease	☐	☐
Sinus Problems	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Tuberculosis	☐	☐
Tumors or Growths	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Yellow Jaundice	☐	☐

Have you had a serious illness not listed ? **Yes** ☐ **No** ☐
If yes: ____________________

Are you Allergic to any of the following?

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

Other: ____________________

Are you under a physicians care now? YES or NO
If yes, please explain ____________________

Have you ever been hospitalized or had a major operation? YES or NO
If yes, please explain ____________________

Have you ever had a serious head or neck injury? YES or NO

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

Do you take, or have you taken Phen-Fen or Redux? YES or NO

Have you ever taken Fosamax, Boniva, Actonel or and other medications containing bisphosphonates? YES or NO

Are you on a special diet? YES or NO

Do you use tobacco? YES or NO

Do you use controlled substances? YES or NO

Women: Are you...
- ☐ Pregnant/trying to get Pregnant
- ☐ Nursing
- ☐ Taking oral contraceptives

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 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 ____________________