Thank you for selecting our dental team! We will always offer you the most up-to-date dental care available today. To help us meet our dental needs, please fill out these forms. Yes, we hate forms too, but this information is important. Thank you for your cooperation!

Dr. Stovall and Team

Personal Information

Date: SSN

Name

Address

City State Zip Code

☐ Male ☐ Female ☐ Single ☐ Married

Home Phone

Work Phone

Cell

E-mail

Employer

Occupation

In Case of Emergency Contact:

Name

Phone

Responsible Party (if different from above)

Name

Address

City State Zip Code

Relation To Patient

SSN

Date of Birth

Drivers Licence #

Insurance Information

Name of Insured

Relationship to Patient

Birth Date of Insured

SSN

Employer

Insurance Co.

Group #

I certify that I, and/or my dependent(s) have insurance coverage with the above named company and assign directly to Dr. Stovall all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I authorize Dr. Stovall or his employees to release any information concerning my dental treatment or my child's to third party payers and/or health practitioners.

Signature of patient or parent if minor

Is patient covered by another insurance? ☐ Yes ☐ No

Complete only if answered yes to above:

Name of Insured

Relationship to Patient

Birth Date of Insured

SSN

Employer

Insurance Co.

Group #

Financing Information

Our goal is to provide you with optimal care based on your individual needs. To assist you in receiving this care, we offer several payment options. You can choose to pay by cash, check, major credit card, or we offer No Interest Payment Plans in addition to Extended Payment Plans through CareCredit, a division of GE Consumer Finance.

Would you be interested in discussing one of our payment options? ☐ Yes ☐ No

Patient Name _____ Date of Birth _____

Dental History or Concerns

Reason for today's visit: _____

Former Dentist _____ Date of last visit: _____ X-rays taken: _____

What did you not like about your past dental appointments?

☐ Was treatment uncomfortable? ☐ Was the staff unfriendly?

☐ Were changes not explained before the appointment? ☐ Other _____

Appearance:

Are you happy with the color of your teeth? ☐ Yes ☐ No Are you happy with their overall appearance? ☐ Yes ☐ No

Is there anything you would like to change? _____

Missing Teeth:

Do you have any missing teeth? ☐ Yes ☐ No Date of extraction _____ Do you have a denture or partial? ☐ Yes ☐ No

Is your denture or partial comfortable? ☐ Yes ☐ No

Have you had any of the following?:

Bad breath	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Bleeding Gums	☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No		
Cigarette, Pipe or Cigar Smoking	☐ Yes ☐ No	Gums swollen or tender	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No		
Dry mouth	☐ Yes ☐ No	Lip or cheek bitting	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No		
Clicking or popping jaw	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No	Sensitivity to biting	☐ Yes ☐ No		
		Pain when brushing	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No		

How often do you floss? _____ How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you had any of the following?

Herpes	☐ Yes ☐ No	Fainting/Dizziness	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Describe Mental Disorder:
Artificial Joints	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	
Cough, persistent/bloody	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Tumor/Growth on head or neck	☐ Yes ☐ No	
Chemical dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Mental disorder	☐ Yes ☐ No	

Recent studies have shown a link between Diabetes and Periodontal Disease. It is important to your health that they both be under control. The warning signs of Diabetes are frequent trips to the bathroom, thirsty all the time, and always feeling hungry.

Blood:

AIDS/HIV ☐ Yes ☐ No Anemia ☐ Yes ☐ No Your Normal Blood Pressure: _____

Hepatitis ☐ A ☐ B ☐ C ☐ D High Blood Pressure ☐ Yes ☐ No Bleeding abnormally with extractions or surgery ☐ Yes ☐ No

Heart Problems:

Artificial Heart Valves	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Do you take antibiotics for dental appointments
Heart Murmur	☐ Yes ☐ No	Pace Maker	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	☐ Yes ☐ No

Breathing/Lungs:

Asthma ☐ Yes ☐ No Tuberculosis ☐ Yes ☐ No Emphysema ☐ Yes ☐ No

Shortness of Breath ☐ Yes ☐ No Respiratory Disease ☐ Yes ☐ No Do you Smoke? ☐ Yes ☐ No

Cancer:

Have you ever had Cancer? ☐ Yes ☐ No What Kind of Cancer did you have? _____ When did you have it? _____

Do you have Cancer? ☐ Yes ☐ No Radiation Treatment ☐ Yes ☐ No Chemotherapy ☐ Yes ☐ No

Women:

Taking birth control ☐ Yes ☐ No Are you pregnant ☐ Yes ☐ No Due Date _____

Allergies:

Aspirin ☐ Yes ☐ No Codeine ☐ Yes ☐ No Iodine ☐ Yes ☐ No

Local Anesthetic ☐ Yes ☐ No Sulfa ☐ Yes ☐ No Others _____

Penicillin ☐ Yes ☐ No Latex ☐ Yes ☐ No

Medications:

Current Medications (if any) _____

Print Form

Submit by Email