Dr. Hughes & Dr. Cress

Date_____

Name_____DOB_____SSN_____

Address_____City_____State_____Zip_____

Phone# _____ Cell #_____email address_____

Patient or Parent Employer_____Work Phone_____

Spouse Name_____Employer_____

Emergency Contact_____Phone_____

1st Insurance Subscriber_____DOB_____SSN_____

Name of Employer_____Insurance Co. _____

2nd Insurance Subscriber_____DOB_____SSN_____

Name of Employer_____Insurance Co._____

Payment Policy

Payment of Services: Payment is due at time of service; if you have insurance we will gladly bill them. If there is a co-payment please plan on paying that at time of service.

Major Dental Services: Payment due at time of service. We are happy to arrange financing for you if you need assistance.

I have read and understand the policies of Dr. Hughes & Dr. Cress.

Signature _____Date_____

Dr. Hughes & Dr. Cress

Medical History

Patient Name:_____ Birth Date:_____ Date:_____

Although dental personnel primarily treat the area in and around your moth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Have you ever had serious head or neck injury?	Yes	No	If yes
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	

Woman: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	Yes	No	If yes
Other?	Yes	No	If yes

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

AIDS/HIV Positive	Yes	No	Yellow Jaundice	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Diabetes	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Drug Addiction	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Easily Winded	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Emphysema	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problems	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal diseases	Yes	No

Have you ever had any serious illness not listed? Yes No If Yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

Dr. Hughes & Dr. Cress

James P. Hughes, D.D.S.
Justin C. Cress, D.D.S.
834 Falls Ave., Suite 2030
Twin Falls, ID 83301
(208)773-9181
Fax (208)734-8634
hughescressdental@gmail.com

Consent For Release of Records

Doctor Name:_____

Address:_____

_____

Phone:_____

Fax:_____

I give my consent to disclose dental records and/or x-rays of:

Name:_____

Please send requested records:
James P. Hughes, D.D.S.
Justin C. Cress, D.D.S.
834 Falls Ave., Suite 2030
Twin Falls, ID 83301

Signature:_____ Date _____

If signed by parent or guardian, state relationship to patient: _____