Isaac E. Davison, DDS, LTD

1226 S. Washington St. | P.O. Box 330 • Du Quoin, IL 62832-3853 (618)542-8832

Welcome to Dr. Isaac E. Davison, DDS, Ltd.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS#: ___-__-____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Employment

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ Phone: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

I prefer to be contacted by

☐ Cell Phone/Text ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

_____

In an emergency, who should be notified? Please enter name, phone number and relationship below

_____

_____

Complete This Page Only If You Are the Parent/Guardian of the Patient or You Are the Insurance Subscriber

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: ___-__-____ DL#: _____

Email Address: _____ Best time to call: _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Dental Information

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist Name and Phone Number

_____

_____

Approximate date of most recent dental exam and/or dental x-rays

_____

_____

I routinely see a dentist every

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

What is your immediate concern about your dental health?

_____

_____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Check all that apply

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/Have braces or orthodontic treatment
☐ Experiences dry mouth
☐ Sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Whitened or bleached your teeth
☐ Experienced popping and/or clicking of your jaw joint
☐ Difficulty chewing
☐ Clenching or grinding of teeth
☐ Currently or previously wore a bite appliance
☐ Wears removable partial/denture
☐ Gums bleed when brushing or flossing
☐ Diagnosed and/or treated for gum disease
☐ Bone loss around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ Experienced gum recession
☐ Teeth become loose on their own (without injury)
☐ Experienced a burning sensation in your mouth
☐ Snores or wakes up frequently during the night

Isaac E. Davison, DDS, LTD

1226 S. Washington St. | P.O. Box 330 • Du Quoin, IL 62832-3853 (618)542-8832

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *No Pre-med
- ☐ Arthritis/Rheumatism
- ☐ Bisphosphonates
- ☐ Cancer
- ☐ Gastric Issues
- ☐ Heart Attack/Stroke
- ☐ HIV+/AIDS
- ☐ Mental Disability
- ☐ Parkinson's Disease
- ☐ Sinus Problems
- ☐ Tumors/Growths
- ☐ *Pre-Med
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Diabetes Type I/II
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Neuro Disorder
- ☐ Prev.Drug/Alch Abuse
- ☐ Sleep Disorder
- ☐ Allergies
- ☐ Auto Immune Disorder
- ☐ Blood Thinners
- ☐ Dizziness/Fainting
- ☐ Head/Neck Injuries
- ☐ Hepatitis A/B/C
- ☐ Liver Disease
- ☐ Organ Transplant
- ☐ Respiratory Problems
- ☐ Steroid Patient
- ☐ Alzheimers/Dementia
- ☐ Birth control pills
- ☐ Blood Transfusion
- ☐ Epilepsy/Seizures
- ☐ Headaches/Migraines
- ☐ High Blood Pressure
- ☐ Medication
- ☐ Pacemaker/Stents
- ☐ See Pt. Note
- ☐ Thyroid Condition

☐ Presently being treated for any other illness ☐ Tobacco/Alcohol Use ☐ Pregnant/Planning Pregnancy/Nursing

If any conditions or alerts selected needs further clarification or enter pregnancy due date, please describe below

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

Name of physician and date of last physical exam

_____

_____

Name and phone number of preferred pharmacy

_____

_____

Describe any current medical treatment, recent hospitalizations or impending surgery below

_____

_____

List all medications (prescription and non-prescription), including regular dosages of aspirin.

Please list any allergies and/or allergies to medications.

☐ * By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performing of xrays and oral examinations. This will serve as my electronic signature.

Name of Patient/Parent or Guardian completing this form *

Response Date: ___/___/_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ *By checking this box, I understand the above information and agree with its contents and this will serve as my electronic signature for the AdministrationForm.