



**Please help us keep our records current by filling out the enclosed forms and mailing them back to our office.  
Thank You!**

**Personal Identification**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Name you prefer to be called: \_\_\_\_\_ Title:  Mr.  Mrs.  Miss. Other: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Year-Round Resident:  Yes  No

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

I prefer to be contacted at my:  Home number  Work number  Cell number

Gender:  Male  Female Marital Status:  Divorced  Married  Single  Separated  Widowed

Birth date: \_\_\_\_\_ Soc. Sec. #: (only if you have insurance) \_\_\_\_\_

Party Responsible for Payment:  Self  Spouse  Parent  Caregiver  Other \_\_\_\_\_

Name of Responsible Party: \_\_\_\_\_ Signature: \_\_\_\_\_

**Insurance Information**

Dental Insurance Company (if applicable): \_\_\_\_\_ Group/ID #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Subscriber:  Self  Spouse  Parent  Other Subscriber Name: \_\_\_\_\_

**Employment Status**

Employer (School if student): \_\_\_\_\_ Title (Major if student): \_\_\_\_\_

Employer/School Address: \_\_\_\_\_

**Emergency Contact Information**

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone Number: (\_\_\_\_\_) \_\_\_\_\_

**Medical Information**

Primary Care Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Are you under a physician's care now?  Yes  No Reason: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No Reason: \_\_\_\_\_

Please list any medications you are currently taking:

Medication	Reason	Medication	Reason

Do you use tobacco?  Yes  No Type: \_\_\_\_\_ Are you currently pregnant?  Yes  No

Do you have any known allergies?  Aspirin  Penicillin  Codeine  Latex  Sulfa  Other \_\_\_\_\_

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

- AIDS/HIV Positive
- Alzheimer's Disease
- Anemia
- Angina
- Artificial Heart Valve
- Artificial Joint
- Cancer
- Chemotherapy
- Cold Sores/Fever Blisters
- Congenital Heart Disorder
- Diabetes
- Emphysema
- Epilepsy/Seizures
- Excessive Bleeding
- Fainting Spells
- Frequent Headaches
- Glaucoma
- Hay Fever
- Heart Attack/Failure
- Heart Murmur
- Heart Pacemaker
- Heart Trouble/Disease
- Hepatitis A
- Hepatitis B or C
- Herpes
- High Blood Pressure
- Hypoglycemia
- Irregular Heartbeat
- Kidney Problems
- Liver Disease
- Mitral Valve Prolapse
- Pain in Jaw Joints
- Radiation Treatment
- Rheumatic Fever
- Scarlet Fever
- Sinus Trouble
- Tuberculosis
- Yellow Jaundice

Have you had any serious illness not listed above? \_\_\_\_\_

Do you take antibiotics before dental work?  Yes  No Reason: \_\_\_\_\_

Prescribing Doctor: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Type prescribed: \_\_\_\_\_ Dosage: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you see another dentist for cleanings? Dentist: \_\_\_\_\_ Frequency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



M. Johnson Hagood, DDS  
Fine Restorative & Cosmetic Dentistry

## **Appointment Change and Cancellation Policy**

Appointments are considered confirmed when they are made. Our office requires two business days notice for appointment change requests. This includes requests for changes in time, date, treatment, provider, or appointment cancellation. Please note that should you leave a request for change on our voicemail when the office is closed, we will consider the request to have been made on the following business day.

Should you fail to give the required two business days notice for appointment changes, you will be charged a fee. This fee could be up to and including the full fee for the appointment you changed, cancelled, or missed.

I have read and understand the Appointment Change and Cancellation Policy.

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Sign

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Date