F. Lee McLemore, D.D.S.

Family Dentistry

610 Eureka Street
Weatherford, TX 76086
(817) 594-8665

Welcome!

*Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill
out this form completely. If you have any questions or
need assistance, please ask us - we will be happy to help.*

Social Security # _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Employer (or Parent's Employer) _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Social Security # _____

Employer _____ Work Phone _____

☐ Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

☐ Payment in full at each appointment. For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

☐ DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

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Eaglesoft Medical History

Patient Name_____ Birth Date_____ Today's Date_____

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

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 a 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, Bonita, Antonella's or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes_____
Are you on a special diet?	☐ Yes	☐ No	If yes_____
Do you use tobacco?	☐ Yes	☐ No	If yes_____
Do you use controlled substances?	☐ Yes	☐ No	If yes_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other_____

Women: Are you.....

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

Do you have, or have you had, any of the following? Check all that apply.

- ❒ AIDS/HIV Positive
- ❒ Alzheimer's Disease
- ❒ Anaphylaxis
- ❒ Anemia
- ❒ Angina
- ❒ Arthritis/Gout
- ❒ Artificial Heart Valve
- ❒ Artificial Joint
- ❒ Asthma
- ❒ Blood Disease
- ❒ Blood Transfusion
- ❒ Breathing Problems
- ❒ Bruise Easily
- ❒ Cancer
- ❒ Chemotherapy
- ❒ Chest Pains
- ❒ Cold Sores/Fever Blisters
- ❒ Congenital Heart Disorder
- ❒ Convulsions
- ❒ Cortisone Medicine
- ❒ Diabetes
- ❒ Drug Addiction
- ❒ Easily Winded
- ❒ Emphysema
- ❒ Epilepsy or Seizures
- ❒ Excessive Bleeding
- ❒ Excessive Thirst
- ❒ Fainting Spells/Dizziness
- ❒ Frequent Cough
- ❒ Frequent Diarrhea
- ❒ Frequent Headache
- ❒ Genital Herpes
- ❒ Glaucoma
- ❒ Hay Fever
- ❒ Heart Attack/Failure
- ❒ Heart Murmur
- ❒ Heart Pacemaker
- ❒ Heart Trouble/Disease
- ❒ Hemophilia
- ❒ Hepatitis A
- ❒ Hepatitis B or C
- ❒ Herpes
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Hives or Rash
- ❒ Hypoglycemia
- ❒ Irregular Heartbeat
- ❒ Kidney Problems
- ❒ Leukemia
- ❒ Liver Disease
- ❒ Low Blood Pressure
- ❒ Lung Disease
- ❒ Mitral Valve Prolapse
- ❒ Osteoporosis
- ❒ Pain in Jaw/Joints
- ❒ Parathyroid Disease
- ❒ Psychiatric Care
- ❒ Radiation Treatments
- ❒ Recent Weight Loss
- ❒ Renal Dialysis
- ❒ Rheumatic Fever
- ❒ Rheumatism
- ❒ Scarlet Fever
- ❒ Shingles
- ❒ Sickle Cell Disease
- ❒ Sinus Trouble
- ❒ Spina Bifida
- ❒ Stomach/Intestinal Disease
- ❒ Stroke
- ❒ Swelling of Limbs
- ❒ Thyroid Disease
- ❒ Tonsillitis
- ❒ Tuberculosis
- ❒ Tumors or Growths
- ❒ Ulcers
- ❒ Venereal Disease
- ❒ Yellow Jaundice

Have you ever had any serious illness not listed on the previous page?

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:

_____ Date:_____

Printed Name of Parent or Legal Guardian:

_____

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PAYMENT POLICY

Payment in full is due at the time services are rendered.

METHOD OF PAYMENT

For your convenience, we offer the following methods of payment. Please check the option you prefer.

❒ **Cash** ❒ **Personal Check** ❒ **Visa** ❒ **MasterCard** ❒ **Discover** ❒ **Am. Express**

DENTAL INSURANCE

** Please read the attached letter concerning our office policy regarding dental insurance. It is yours to keep.*

Any treatment provided which is less than $100 will be paid by the patient. Our office will gladly file the claim for you and your insurance company will then reimburse you. For amounts greater than $100, we will file on your insurance, however, any deductible or co-pay is due at the time services are rendered, or prior to completion of care if multiple appointments are necessary.

I have received the letter regarding dental insurance and understand the payment policy of this office.

Signature of Patient (or parent if minor) Date