MARY PAIGE HUXFORD, DMD, PLLC
TAMMI LOCKHART, DMD

Patient Information

Patient Name ____ Nickname ______________________

Birthdate __________________ SSN ______________________ Age _____ Male Female

Physician ________________________________ School ______________________________

Special Interests (sport, toy pet, etc.) ____

Please check if patient has had any of the following:

___Measles
___Mumps
___Chicken Pox
___Whooping Cough
___Scarlet Fever
___Diphtheria
___Kidney Disease
___Mouth Injuries
___Heart Trouble
___Rheumatic Fever
___Diabetes
___Excessive Bleeding
___Blood Pressure (High/ Low)
___Asthma
___Tuberculosis
___HIV/ AIDS
___Seizures or Convulsions
___Epilepsy
___Congenital Heart Disease
___Anemia
___X-Ray Therapy
___Lung Disease
___Hepatitis

Any disease or problem not mentioned above: ____

Is patient allergic to penicillin? Y N Allergic to latex? Y N Any other allergies ______________________

List any current medications____

Is patient under medical care at this time? Y N Explain ______________________________

List any physical or mental disabilities ____

How did you hear of our office? ____

Whom may we thank for referring you to our office? _________________________________

Date of last dental visit ___________ Doctor ____________________ Last Cleaning ______________

Have dental x-rays ever been taken on your child? Y N

Has our office seen any other children (siblings)in the family? Y N Name ________________________

Reason for this visit ____

Has this patient ever had any unpleasant medical or dental experiences? Y N

Does this patient have any of the following habits? Thumb-sucking Finger-sucking Pacifier Nail biting Breathing through mouth

---

(CONTINUED ON BACK PAGE)

GUARANTOR INFORMATION
****The parent or guardian accompanying the patient is the responsible party for all accounts. ****
All paperwork must be filled out completely and signed by the responsible party.

Father's Name: ____

Address ______________________________________ City __________________________ Zip ____________

SSN ________________________ Birthdate ______________ Employer _____________________________

Home Phone _________________________ Work __________________________ Cell ____________________

E-Mail Address ________________________________ Marital Status: Married Widowed Separated Divorced Single

---

Mother's Name: ____

Address ______________________________________ City __________________________ Zip ____________

SSN ________________________ Birthdate ______________ Employer _____________________________

Home Phone _________________________ Work __________________________ Cell ____________________

E-Mail Address ________________________________ Marital Status: Married Widowed Separated Divorced Single

---

Legal Guardian (if other than mother or father): ____

Address ______________________________________ City __________________________ Zip ____________

SSN ________________________ Birthdate ______________ Employer _____________________________

Home Phone _________________________ Work __________________________ Cell ____________________

E-Mail Address ________________________________ Marital Status: Married Widowed Separated Divorced Single

---

INSURANCE

Name of Primary Dental Insurance ____ Telephone____________________

Name of Policy Holder ____ Birthdate ____________________

Relation to patient __________________ID Number __________________________ Group Number_______________

Employer ____ Employer Phone________________________

Name of Secondary Dental Insurance ______________________________________ Telephone____________________

Name of Policy Holder ____ Birthdate ____________________

Relation to patient __________________ID Number __________________________ Group Number_______________

Employer ____ Employer Phone________________________

I have received and read a copy of this office's office policy. The information I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in the patient's or responsible party's status.

I hereby authorize the dental staff to perform the necessary dental services this patient may need.

Signature ____ Date _____________________