Dr. James B. Tankersley, Jr.
Upstate Dental Surgery

Date: _____

Name of Patient: _____ _____ _____ Goes By: _____
First M.I. Last

Date of Birth: _____ Sex: M ☐ F ☐ Age: _____ Weight: _____ S.S.#: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Business: _____Cell: _____

Employed by: _____ City: _____ Occupation: _____

Student: Y ☐ N ☐ Where? _____ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Name of Spouse: _____ Employed by: _____

Family Dentist: _____ Family Physician: _____

Orthodontist: _____ Who referred you to our office? _____

Emergency Name & Telephone Number: _____

If minor, Name of Parent(s)/Guardian: _____ Work #: _____

INSURANCE INFORMATION

Do you have Dental Insurance? Yes ☐ No ☐

PRIMARY

Name of Insured: _____ D.O.B. _____
S.S. # of Insured: _____
Relationship to Patient: _____
Insured's Employer: _____ Tel: _____
Group #: _____
Name of Insurance Co.: _____
Address for Claims: _____
_____

SECONDARY

Name of Insured: _____ D.O.B. _____
S.S. # of Insured: _____
Relationship to Patient: _____
Insured's Employer: _____ Tel: _____
Group #: _____
Name of Insurance Co.: _____
Address for Claims: _____
_____

Do you have Major Medical and/or Medicare Insurance? Yes ☐ No ☐

PRIMARY

Name of Insured: _____ D.O.B. _____
S.S. # of Insured: _____
Relationship to Patient: _____
Insured's Employer: _____ Tel: _____
Group #: _____
Name of Insurance Co.: _____
Address for Claims: _____
_____

SECONDARY

Name of Insured: _____ D.O.B. _____
S.S. # of Insured: _____
Relationship to Patient: _____
Insured's Employer: _____ Tel: _____
Group #: _____
Name of Insurance Co.: _____
Address for Claims: _____
_____

ASSIGNMENT OF INSURANCE BENEFITS
GUARANTEE OF PAYMENT

For surgical services rendered, the undersigned hereby assigns all insurance benefits payable to or on behalf of the undersigned to the extent of the surgical charges. I understand that should there be any overpayment, it will be refunded to me, but that I will be responsible for any charges not covered. This signature serves as request for payment for services rendered by James B. Tankersley, Jr. and authorizes release of any medical information needed to process insurance claims.

_____ _____ _____
DATE SIGNATURE RELATIONSHIP TO PATIENT, IF MINOR

MEDICARE PATIENTS ONLY: I have been notified that Medicare may not cover these services. I agree to be fully responsible for all non-covered charges.

_____
DATE SIGNATURE

Dr. James B. Tankersley, Jr.
Upstate Dental Surgery

Name of Patient: _____

MEDICAL HISTORY RECORD

Have you ever had: (check box yes or no)

YES	NO		YES	NO		YES	NO	
☐	☐	Heart Trouble	☐	☐	Swelling of Ankles	☐	☐	Tuberculosis
☐	☐	Rheumatic Fever	☐	☐	Shortness of Breath	☐	☐	Nervous Disorders
☐	☐	High Blood Pressure	☐	☐	Convulsions	☐	☐	Anemia
☐	☐	Heart Murmur	☐	☐	Asthma	☐	☐	Hepatitis/Liver Trouble
☐	☐	Chest Pain	☐	☐	Kidney Trouble	☐	☐	Glaucoma
☐	☐	Any Surgery	☐	☐	Emphysema	☐	☐	AIDS (HIV Infection)
☐	☐	Herpes	☐	☐	Fainting Spells	☐	☐	Sickle Cell Disease/Trait
☐	☐	Diabetes						

YES ☐ NO ☐ 1. Are you now, or have you been within the past two years, under the care of a physician?
What for? _____ When? _____

YES ☐ NO ☐ 2. Have you ever taken CORTISONE (prednisone or other steroids)?

YES ☐ NO ☐ 3. Have you ever taken anti-coagulants (blood thinners)?

YES ☐ NO ☐ 4. Have you ever taken tranquilizers or sedatives?

YES ☐ NO ☐ 5. Have you ever used recreational drugs?

YES ☐ NO ☐ 6. Have you ever been treated for drug or alcohol addiction?

YES ☐ NO ☐ 7. Have you ever taken heart medicine or medicine for high blood pressure?

YES ☐ NO ☐ 8. Are you taking any kind of medicine, drug or pills for any purpose?
If so, what? _____

YES ☐ NO ☐ 9. Are you allergic to any food, drug or medicine?
If so, what? _____

YES ☐ NO ☐ 10. Have you ever had any problems when taking codeine?

YES ☐ NO ☐ 11. Have you ever had hives or wheezing after an injection?

YES ☐ NO ☐ 12. Have you ever had prolonged bleeding following a scratch, cut or tooth extraction?

YES ☐ NO ☐ 13. Do you wear contact lenses?

YES ☐ NO ☐ 14. Do you smoke a pack or more of cigarettes a day?

YES ☐ NO ☐ 15. Have you ever had radiation treatment for a skin disease or tumor?

YES ☐ NO ☐ 16. If female, are you now pregnant?

YES ☐ NO ☐ 17. At the present time, do you have a cold, cough or stuffy nose?

YES ☐ NO ☐ 18. Do you have any disease, condition, or problem not listed above that you think I should know about? _____

_____

_____