Reginald Ligon, D.D.S.
Mendee B. Ligon, D.D.S.

Welcome to our practice! In maintaining our philosophy of excellence in dentistry it is important that you provide us with an accurate dental and medical history. Thank you for your cooperation.

NAME: ______________________ BIRTH DATE: ______________

ADDRESS: ______________________ APT: __________

CITY: ______________ ZIP CODE: ________ TELEPHONE: ____________

CELL PHONE: ______________ E-MAIL ADDRESS: ______________

MARITAL STATUS: __________ SOCIAL SECURITY#: ______________

OCCUPATION: ______________________________

EMPLOYER: ______________________ BUSINESS TELEPHONE: ____________

EMPLOYER'S ADDRESS: ______________________________

SPOUSE'S EMPLOYER: ______________________ BUSINESS TELEPHONE: ____________

EMPLOYER'S ADDRESS ______________________________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________

ACCOUNT TO BE PAID BY: CHECK ❑ CHARGE ❑ CASH ❑ CARE CREDIT ❑

CARE CREDIT – ASK ABOUT INTEREST FREE FINANCING – 3-6-12-18 MONTHS – APPLY TODAY!

DO YOU HAVE DENTAL INSURANCE: YES ❑ NO ❑

COMPANY: ______________ POLICY #: ______________

HEALTH HISTORY

	YES	NO
ARE YOU UNDER THE CARE OF A MEDICAL DOCTOR AT PRESENT?	❑	❑
PHYSICIAN'S NAME ______________________		
ADDRESS ______________ PHONE ______________		
ARE YOU TAKING ANY MEDICATION, DRUGS, PILLS?	❑	❑
IF YES (1) NAME ______________________		
(2) USE ______________________		
ARE YOU ALLERGIC TO ANY MEDICATIONS?	❑	❑
❑ PENICILLIN ❑ ASPIRIN ❑ CODEINE ❑ ERYTHROMYCIN		
❑ OTHER ______________________		
ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATION OR SUBSTANCE?	❑	❑
WOMEN: ARE YOU PREGNANT?	❑	❑
HAS YOUR MEDICAL DOCTOR EVER SAID YOU HAVE CANCER OR A TUMOR?	❑	❑
HAVE YOU EVER HAD EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT?	❑	❑

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE NOW OR HAVE HAD IN THE PAST:

- ❑ ANEMIA / BLOOD DISORDER
- ❑ HIGH BLOOD PRESSURE
- ❑ ASTHMA
- ❑ BLOOD TRANSFUSIONS
- ❑ HEART DISEASE / ATTACK
- ❑ HEART PACE MAKER
- ❑ ARTIFICIAL HEART VALVES
- ❑ HIP/JOINT REPLACEMENT
- ❑ MITRAL VALVE PROLAPSE
- ❑ DIABETES
- ❑ EPILEPSY OR DIZZY SPELLS
- ❑ COLD SORES / FEVER BLISTERS
- ❑ RHEUMATIC FEVER
- ❑ HEPATITIS A (INFECTIOUS)
- ❑ HEPATITIS B (SERUM)
- ❑ HEPATITIS C
- ❑ HIV POSITIVE / AIDS RELATED SYMPTOMS?
- ❑ HAVE YOU EVER TAKEN PHEN-FEN?

❑ HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL PROCUDURE OR SERIOUS ILLNESS YES ❑ NO ❑

IS THERE ANY INFORMATION CONCERNING YOUR HEALTH WHICH WE SHOULD BE AWARE OF?

IF SO, PLEASE EXPLAIN: ____________________

HAVE YOU EVER TAKEN ORAL OR INTRAVENOUS (IV) BISPHONATES FOR OSTEOPOROSIS OR CANCER THERAPY EX: FOSOMAX, BONIVA, AREDIA, ZOMETA OR ACTONEL? IF SO, WHICH ONE AND FOR HOW LONG? ____________________

DENTAL HISTORY

DO YOU FIND YOURSELF GRINDING OR CLENCHING YOUR TEETH? ____________________

DO YOU HAVE HEADACHES? ____________________

ARE YOU INTERESTED IN WHITENING YOUR TEETH IN 1 HOUR? ____________________

DO YOU LIKE YOUR SMILE? ____________________

DO YOU SMOKE? ____________________

DO YOU DRINK A LOT OF SODA? ____________________

DATE OF LAST DENTAL VISIT: ____________________

ANY X-RAYS TAKEN IN THE PAST 3 YEARS? ____________________

ARE YOU HAVING PAIN OR DISCOMFORT AT THIS TIME? ____________________

HAVE YOU EVER HAD A BAD EXPERIENCE IN A DENTAL OFFICE? ____________________

ALLERGIES TO ANY METALS? ____________________

HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? ____________________

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT RESPONSIBILITY FOR DENTAL SERVICES PROVIDED IS DUE AND PAYABLE WHEN RENDERED. I AUTHOPRIZE MY INSURANCE TO PAY DIRECTLY TO MY DENTIST. I AGREE TO BE RESPONSIBLE FOR ANY UNPAID BALANCE.

PATIENT SIGNATURE ____________________ DATE ____________

PARENT SIGNATURE ____________________ DATE ____________
(IF UNDER AGE 18)