Welcome!

Thank you for choosing Dr. James E. Montgomery, DDS to for your dental needs! Our goal is to ensure your utmost comfort and satisfaction. If there is anything that we can do to make your visit more comfortable, please let us know.

Unfortunately, we do not accept insurance payments at this time. However, we will be happy to file your insurance claim for you and have the insurance payment sent directly to you.

Patient Information:

Name: ____ Today's date: _______________

First MI last

Birthdate: _______/_______/_______ Social Security #: ______ – ______ – ________

Cell phone #: (______) ______ – ________ Other contact #: (______) ______ – _______

Home address: _____________________________________ City: _______________________

state: ___________ zip: ____________ E-mail address: ______________________________

Check appropriate box(es) : ☐ minor ☐ single ☐ married ☐ Student

Spouse/Parent's name(s): ______________________ Phone #: (______) ______ – ______

Employer: __________________________________ State: ________ Zip: ______________

Person to contact in case of emergency: ____________________________________

Relationship: _________________________ Phone #: (______) _______ – ________

How did you hear about us? ☐ Yellowpages (online or print) ☐ internet ad

☐ our website ☐ word of mouth ☐ other: ______________________________

Whom may we thank for referring you? ____

Person responsible for this account: self / other: ______________________________

Relationship: _________________________ Phone #: (______) _______ – ________

Additional Information:

Preferred Pharmacy: Publix / walmart / walgreens / cvs / Other: _______________

Located in (City): _________ _____________________________

Pharmacy telephone number: (_______) _______ – ________

Consent: I hereby authorize Dr. James E. Montgomery, DDS to use the health information I provide on the following page for my dental treatment.

____ _________________

Signature of patient or parent (if minor) date

Medical history

- Do you have any general health problems at this time? If you do, please specify: ____________ ____ YES NO
- are you presently under a physician's care? If yes, for what reason? ___________________________ YES NO
- have you been hospitalized within the past five years? If yes, for what reason? ________________ ____ YES NO
- have you had radiation or chemotherapy? If yes, for what reason? ___________________________ ____ YES NO
- are you currently taking any drugs or medications? If yes, what are you taking, how much, how frequently. (this includes aspirin, etc.) ____ ____ YES NO
- are you allergic to any medications? If yes, list all. ____ Yes NO
- have you been tested for hiv? If yes, what were the results? Yes NO
- are you on a special diet? Yes NO
- are you or have you ever been afflicted with any of the following:

☐ allergies
☐ fainting spells
☐ ear problems
☐ tobacco use
☐ high blood pressure
☐ healing problems
☐ venereal disease
☐ lung, breathing problems
☐ Diabetes
☐ Glaucoma
☐ Epilepsy
☐ Hepatitis
☐ Heart ailments (murmers)
☐ Mental disorder
☐ Nervous disorder

- are you experiencing any dental discomfort at this time? If yes, where and for how long? ____ YES NO
- do you grind your teeth? YES NO
- do your gums bleed, are swollen or irritated? YES NO
- has a dental visit ever been very unpleasant? YES NO