CARTER DENTAL | SCOTT CARTER, D.M.D. | 7915 WEST USTICK RD | BOISE, ID 83704 | 208.376.7599

Date:_____

Patient Information

First Name M.I. Last	Birthdate	Social Security #

Home Address	City, State, Zip	Home Phone

Cell Phone	E-Mail Address

Your Employer	Occupation	Business Phone

Spouse/Parent Name	Occupation	Business Phone

Nearest Relative Not Living With You	Relationship	Phone

How would you like to be reminded of your appointments? **(circle one)** Phone or E-mail

Parental Consent for Dental Services
I hereby Authorize Necessary Dental Services For _____ Initials _____

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

Financial Information

Person responsible for this account Name	Relationship	Home Phone

Address	City, State, Zip	Social Security #

Insurance Release: I authorize release of any information required by my insurance Signature: _____

Payment Release: I authorize my insurance benefits to benefits to be paid directly to Carter Dental

Signature:

I acknowledge that I have been offered a copy of Dr. Scott Carter's Notice of Privacy Practices Please Initial: _____

(Please Continue on back)

Medical History

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

(PLEASE CIRCLE THOSE THAT APPLY)

AIDS / HIV positive	Dizziness	Kidney Disease	Radiation Treatment
Anemia	Drug Abuse	Liver Disease	Respiratory Treatment
Arthritis	Epilepsy	Metal Allergy	Rheumatic Fever
Artificial Joints / Pins	Excessive Bleeding	Mitral valve Prolapse	Sinus Problems
Artificial Heart Valve	Glaucoma	Nervous Disorder	Stroke
Asthma	Head Injuries	Pacemaker	Thyroid Disorder
Blood Disease	Heart Disease	Penicillin Allergy	Tuberculosis
Blood Transfusion	Heart Murmur	or other Drug Allergy	Tumors
Cancer	Hepatitis	Pregnancy:	Tobacco Use:
Diabetes	High Blood Pressure	Due Date:	How often?

**** Please initial if you have none of the above.*** _____

ARE YOU TAKING ANY MEDICATION NOW? *YES* *NO* (Please circle one.)

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING : _____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATION NOW? *YES* *NO* (Please circle one.)

DO YOU HAVE A LATEX ALLERGY? *YES* *NO* (Please circle one.)

DO YOU HAVE ANY HEALTH PROBLEMS THAT NEED FURTHER CLARIFICATION? *YES* *NO*

IF YES, PLEASE EXPLAIN: _____

_____

_____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, I WILL INFORM THE DOCTOR AT THE NEXT APPOINTMENT.

_____ _____

SIGNATURE OF PATIENT/PARENT/ OR GUARDIAN **DATE**