Heisch, Gartz and Cannon

106 Longview- Suite A • White Rock, NM 87547 (505)672-1336

Welcome to High Mesa Dental Arts

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Insurance Information

Primary Dental Insurance:

***ID Number is typically insurance holders social security number**

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

☐ **By checking this box I acknowledge that High Mesa Dental Arts is a Premier Provider for Delta Dental, GEHA, and Cinga. All other insurance providers are considered out of network. We are NOT providers for medicaid or medicare.**

Secondary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ Alcoholism
- ☐ Allergy - Fentnal
- ☐ Allergy - Nuts
- ☐ Allergy- Tree Nuts
- ☐ A-polyethyleneglycol
- ☐ Asthma
- ☐ Blood Thinner
- ☐ cephalosporin
- ☐ Dementia
- ☐ EDS3 Hypermobility
- ☐ Fainting
- ☐ Hard of Hearing
- ☐ Heart Pacemaker
- ☐ Hip Replacment
- ☐ Knee Replacement
- ☐ Liver Transplant
- ☐ MCTD
- ☐ Multiple Sclerosis
- ☐ Organ Transplant
- ☐ Perio Surgery
- ☐ Radiation Treatment
- ☐ Shingles
- ☐ Stroke
- ☐ Use of Tobacco
- ☐ Allergy - All NUTS
- ☐ Allergy - Larazapam
- ☐ Allergy - Penicillin
- ☐ Allergy-LevoFloxacin
- ☐ Arthritis
- ☐ Autism
- ☐ Blood Transfusion
- ☐ Chemotherapy
- ☐ Dental Implant
- ☐ Endocarditis
- ☐ Fibromyalgia
- ☐ Head Injuries
- ☐ Heart Valve
- ☐ HIV
- ☐ lemons
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mystenia Gravis
- ☐ Pacemaker
- ☐ Postural Tachydardia
- ☐ Respiratory Problems
- ☐ Shoulder Reconstruct
- ☐ Thyroid Disease
- ☐ Allergy Amoxicillin
- ☐ Allergy - Latex
- ☐ Allergy - Quinolones
- ☐ Alzheimer's
- ☐ Artificial Joints
- ☐ Behavior Problems
- ☐ Bruise Easily
- ☐ Cold Sores (Herpes)
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ hypothyroidism
- ☐ levaquin
- ☐ Lung Disease
- ☐ met Breast Cancer
- ☐ Naproxin
- ☐ Pain in Jaw Joints
- ☐ Pregnant / Nursing
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Allergy - Clindamyci
- ☐ Allergy - Narcotics
- ☐ Allergy- tomatoes
- ☐ Anemia
- ☐ Artificial Valve (H)
- ☐ Blood Disease
- ☐ Cancer
- ☐ COPD
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Guillian Beret Syndr
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraines
- ☐ Narcotics Issue
- ☐ Parkinson's
- ☐ Psychiatric Tx
- ☐ Sensitive Teeth
- ☐ Sleep Apnea
- ☐ Tumors

If any condition or alert selected above needs further clarification, please explain below:

_____

_____

_____

Are you allergic or have you had any adverse reaction (i.e. itching, rash, swelling or hands, feet or eyes) to anymedications?

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor