RICHARD D. WALTER, D.M.D.

NEW PATIENT/ UPDATE FORM

Patient's Name: _____ Date of Birth: ___/___/___ Date:___/___/___

Name Of Parent (If child), Guardian, or POA: _____

Marital Status: S M W D SS#: _____-_____-_____ Drivers License #: _____ Sex: M F

Permanent Address: _____ City: _____ St: _____ Zip: _____

Temporary Address: _____ City: _____ St: _____ Zip: _____

Home phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____ ext: _____

Cell phone: ( ) _____ - _____ E-Mail Address: _____

Employer: _____ Department: _____

Name of Physician: _____ Phone #: ( ) _____ - _____

Medications presently taking: _____

_____

Are you allergic to any of the following medications? Please Circle

Penicillin Aspirin Codeine Erythromycin Tetracycline Acetaminophen Clindamycin Cephalexin Latex

Are you taking Blood Thinner? _____ Name of Medication: _____

Have you had any knee, hip, or other bone replacement? *Dates:* _____

Has a physician ever informed you to take an antibiotic before dental treatment? Yes / No

Do you have any history of taking medicine for Osteoporosis? _____ Any history of Chemotherapy? _____

If female, are you pregnant or nursing? Pregnant / Nursing

Have you had any of the following? Please Circle

Heart Attack	**Coronary Insufficiency**	**Epilepsy**	**High Blood Pressure**
Heart Murmur	**Pacemaker**	**Tuberculosis**	**Low Blood Pressure**
Prolapsed Mitral Valve	**Chest pains on Exertion**	**Hepatitis A, B, C**	**Venereal Disease**
Heart Stent(s)	**Shortness of Breath**	**AIDS/HIV**	**Liver/Kidney Problems**
Stroke	**Emphysema/COPD**	**Organ Transplant**	**Leaky/Regurgitate Valve**
Diabetes	**GI/Stomach Ulcers**	**Bone Replacement**	**Heart Valve Replacement**
Herpes	**Glaucoma**	**Cancer:_____**	**Rheumatic Heart Disease**

I understand payment is expected at the time of service unless you agree to file my insurance. If however, after 90 days my insurance has not paid my claim, I will be expected to pay my balance for full services rendered to me. I understand if my account is placed for collection, a fee of 35% of the balance due or 5% interest will be added to my account, whichever is greater. I authorize Richard D. Walter, D.M.D. to contact me at home or at work to discuss any matter related to this form or any dental treatment. I have read the conditions stated relating to treatment and payment and agree to their consent.

_____

Signature of Patient, Guardian, or POA Date