Patient Information

Name_____ Birth Date_____ SS#_____
Address_____ City/Zip _____
Home Phone_____ Business Phone_____ Cell Phone_____
E-mail_____ Marital Status S M D W
Driver's License #_____ Full-time student Y N If yes, where? _____
What is your preferred method of contact? Home Business Cell Email
Who may we thank for referring you to our office? _____
Name/number of nearest relative not living with you in case of emergency _____

Dental Insurance

As a courtesy to our patients our office will file primary insurance forms. However, insurance coverage is a contract between the patient, employer and insurance company. The ultimate responsibility is with the patient. We can only estimate your insurance coverage based on information we receive from you. All other fees are due at the time of service. If you would like assistance with your insurance please fill out the following:

Employee or account holder_____ Employee SS#_____
Employer_____ Occupation_____
Employee Date of Birth_____ Insurance Company_____
Phone Number for insurance co._____ Group #_____

In order to assist with insurance forms you will need the following:
1. Benefits booklet which outlines coverage.
2. Contact information or current insurance card for your insurance carrier.

Dental History

Former Dentist name/Phone number_____ Date of last visit_____
Have you ever had major dental treatment? When and what kind? _____
Do you have any pain or sensitivity with your teeth or gums? _____
Do you clench or grind your teeth? Y N Do you find yourself brushing too hard? Y N
Do you have jaw or joint pain? Y N Clicking or popping? Y N Painful opening? Y N
Do you smoke or use smokeless tobacco products? Y N If yes, what kind and how long? _____
Do you wear full/partial dentures? Y N How old are they? _____ Do they fit comfortably? _____
Are you in overall good health? _____
Have you had difficulty getting numb for dental treatment? Y N
Have you ever had a reaction to any dental anesthesia? Y N _____
Do you currently or have you ever worn orthodontic braces? Y N
Do you have a retainer? Y N If yes, how old is it? _____
Have you ever had an injury to your face or jaw? Y N If yes, please explains? _____
Have you ever had sinus problems? Y N
Have you ever had any of the following?

- o Bleeding gums
- o Loose teeth
- o Bad breath
- o Deep cleaning (known as scaling and root planning)
- o Gum surgery or grafting
- o Oral surgery what kind? _____
- o Fever blisters (cold sores)
- o Mouth ulcers

Cosmetics

Are you happy with the appearance of your teeth? Y N _____
Do you have any of the following?

- o Discolored or yellow teeth
- o Too much gum when smiling
- o Cracked or broken teeth
- o Crooked, crowded or overlapped teeth

Are you interested in bleaching or whitening your teeth? Y N
Are you interested in braces? Y N
Would you like to discuss the cosmetic appearance of your teeth? Y N If yes, what are your concerns?
_____

Medical History

Physician's name_____

What was the date of your last physical? _____

Are you currently being treated for a medical condition? Y N If yes, please explain. _____

Have you been hospitalized or had surgery recently? Y N If yes, please explain. _____

What medications are you currently taking? _____, _____, _____

Have you ever been advised to take an antibiotic prior to dental work? Y N If yes, why? _____

Are you currently taking any blood thinners like Coumadin? Y N If yes, what are you taking? _____

Are you allergic or have you had any reactions to any of the following?

- o Penicillin or Amoxicillin
- o Codeine
- o Erythromycin
- o Demerol
- o Aspirin or Ibuprofen
- o Local anesthesia
- o Latex
- o Other Allergies _____

Have you had any of the following?

- o Infective Endocarditis
- o Congenital heart disease/defects
- o Transplant, What kind? _____
- o Artificial Heart Valves
- o Heart Shunts
- o Mitral Valve Prolapse
- o Rheumatic Fever
- o High Blood Pressure
- o Low Blood Pressure
- o Angina
- o Heart Murmur
- o Stroke
- o Heart Attack
- o Heart Surgery
- o Diabetes
- o Bleeding disorders
- o Anemia
- o AIDS/HIV
- o Hepatitis
- o Fainting
- o Breathing Difficulties
- o Asthma
- o Lung problems or COPD
- o Tuberculosis
- o Thyroid problems
- o Pace Maker
- o Prosthetic joints
- o Emotional or Nervous disorders
- o Back problems
- o Arthritis
- o Headaches
- o Epilepsy
- o Stomach ulcers
- o Cancer, What Kind? _____
- o Radiation therapy or Chemotherapy
- o Kidney problems

Women:

Are you pregnant? Y N Due date? _____ Are you breast feeding? Y N
Are you taking birth control? Y N _____
Are you taking any medications for bone density (Bisphosphonates)? Y N _____
Is there any other medical condition that you would like us to know about? Y N _____

I hereby accept full and complete responsibility for all debts and obligations incurred during the course of the above named patient's treatment by Reich Dental Center. By signing this form I agree to pay all costs of collection including 1 ½ % interest per month on unpaid balances, reasonable attorney fees and court costs. By signing this form, I consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. By signing this form I also understand that it is my responsibility to notify the doctor of any changes in my health and/or medications before any dental treatment.

_____ _____

Signature Date