

## Patient - Information

Patient's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ M \_\_\_\_ F \_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Other \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Employer's Telephone (\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's Occupation \_\_\_\_\_ Drivers's License # \_\_\_\_\_

Family Physician \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

## Responsible Party - Information (If same as Patient, write "SAME" for this section)

Responsible Party Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer Name \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Dental Insurance Information

**Primary Insurance** \_\_\_\_\_ GROUP# \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ GROUP# \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Reynoldsburg Family Dental requests payment at the time services are rendered. Every reasonable effort to assist with insurance will be made. Please understand that insurance company policies are agreements between the insurance company and the patient's employer.

I hereby authorize my insurance benefits to be paid directly to Reynoldsburg Family Dental and realize that I am financially responsible for any fees not covered by insurance. I also authorize Reynoldsburg Family Dental to release any information to the insurance company that it may request to process claims. I will be responsible for cost of this care regardless of insurance coverage and for any costs of collection including attorney's fees and court costs.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY

1. Are you having any dental problems at this time? .....  YES  NO
2. Do your gums bleed at any time? .....  YES  NO
3. Do you feel very nervous about having dental treatment? .....  YES  NO
4. Have you ever had a bad experience in the dental office? .....  YES  NO
5. Have you been a patient in the hospital during the past two years? .....  YES  NO  
If yes, for what reason? \_\_\_\_\_
6. Have you been under the care of a medical doctor during the past two years? .....  YES  NO  
If yes, for what reason? \_\_\_\_\_
7. Have you taken any medicine or drugs during the past two years? .....  YES  NO
8. Do you have any allergies (i.e., itching, rash, swelling of hands, feet or eyes) to any medications? .....  YES  NO  
If yes, please list: \_\_\_\_\_
9. Have you ever had any excessive bleeding requiring special treatment? .....  YES  NO
10. Check any of the following which you have had or have at present:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart Failure                | <input type="checkbox"/> Shortness of Breath             | <input type="checkbox"/> HIV Positive (AIDS)                    |
| <input type="checkbox"/> Heart Disease or Attack      | <input type="checkbox"/> Emphysema                       | <input type="checkbox"/> Hepatitis A (infectious)               |
| <input type="checkbox"/> Angina Pectoris (chest pain) | <input type="checkbox"/> Tuberculosis (TB)               | <input type="checkbox"/> Hepatitis B (serum)                    |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Hepatitis C                            |
| <input type="checkbox"/> Mitral Valve Prolapse        | <input type="checkbox"/> Hay Fever                       | <input type="checkbox"/> Liver Disease                          |
| <input type="checkbox"/> Heart Murmur                 | <input type="checkbox"/> Sinus Trouble                   | <input type="checkbox"/> Yellow Jaundice                        |
| <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> Allergies or Hives              | <input type="checkbox"/> Blood Transfusion                      |
| <input type="checkbox"/> Congenital Heart Lesions     | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Drug Addiction                         |
| <input type="checkbox"/> Scarlet Fever                | <input type="checkbox"/> Thyroid Disease                 | <input type="checkbox"/> Hemophilia                             |
| <input type="checkbox"/> Artificial Heart Valve       | <input type="checkbox"/> Radiation or Cobalt Treatment   | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> Heart Pacemaker              | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Cold Sores or Fever Blisters           |
| <input type="checkbox"/> Heart Surgery                | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Genital Herpes                         |
| <input type="checkbox"/> Artificial Joint             | <input type="checkbox"/> Rheumatism                      | <input type="checkbox"/> Epilepsy or Seizures                   |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Cortisone Medication            | <input type="checkbox"/> Fainting or Dizzy Spells               |
| <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Nervousness                            |
| <input type="checkbox"/> Kidney Trouble               | <input type="checkbox"/> Pain in Jaw Joints              | <input type="checkbox"/> Psychiatric Treatment                  |
| <input type="checkbox"/> Ulcers                       | <input type="checkbox"/> Cosmetic Surgery                | <input type="checkbox"/> Sickle Cell Disease                    |
|   |  | <input type="checkbox"/> Bruise Easily                          |

11. Do you use or have you ever used recreational drugs? .....  YES  NO
12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? .....  YES  NO
13. Do your ankles swell during the day? .....  YES  NO
14. Have you lost or gained more than 10 pounds in the last year? .....  YES  NO
15. Do you use more than two pillows to sleep? .....  YES  NO
16. Do you ever wake up from sleep short of breath? .....  YES  NO
17. Are you on a special diet? .....  YES  NO
18. Has your medical doctor ever said you have cancer or a tumor? .....  YES  NO
19. Do you have any disease, condition or problem not listed above? .....  YES  NO  
If yes, what? \_\_\_\_\_
20. Women: Are you Pregnant?  YES  NO If yes, what month are you due? \_\_\_\_\_  
Are you taking birth control pills? .....  YES  NO
21. List all medications you are taking at this time. \_\_\_\_\_  
\_\_\_\_\_
22. List any medical problems you have been treated for in the past, not mentioned above. \_\_\_\_\_  
\_\_\_\_\_
23. How do you feel about the appearance of your teeth? \_\_\_\_\_  
\_\_\_\_\_
24. If you could change anything about your smile, what would you change? \_\_\_\_\_  
\_\_\_\_\_