Med. Alert____ Pre-Med____ Allergies____ DATE:_____

RAH
D.D.S. P.A.

PATIENT INFORMATION

Name_____ Birthdate_____

Telephone_____ Work #_____ Cell phone #_____

Address_____ City_____ State_____ Zip Code_____

Employer_____ Spouse's Name_____

Soc. Sec. Number_____ E-Mail Address_____

Emergency Contact _____ Relationship_____ Emergency Phone_____

If patient is a minor, who is legally responsible? Please list name, complete address and phone number:

_____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Name of primary insurance_____ Group #_____ Employer_____

Insurance Address_____ Phone # _____

Employee/Subscriber_____ SSN#_____ Birthdate_____

Relationship to Employee_____ Full-time student? _____ Name of School_____ City_____

Is the patient covered by a secondary dental plan? _____ Name of Carrier_____ Group #_____

Insurance Address_____ Phone # _____

Employee/Subscriber_____ SSN#_____ Birthdate_____

Employer_____ Relationship to Employee_____

A service charge of 1-1/2% per month (18% annual rate) will be applied to balances over 60 days, $.50 minimum charge.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the insurance claim. If the patient is a minor, permission is granted for dental treatment, as deemed necessary to be performed in our office or until written notice is given discounting this permission.

Signature required_____ Date_____

Signature required_____ Date_____

What is your chief complaint? _____

Are you happy with your teeth and their appearance? _____ If not, what would you like to see different? _____

Date of your last dental visit: _____ Date of last dental x-rays: _____

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Are your teeth sensitive to cold/hot, sweets or pressure?	☐	☐	☐	Have you ever had periodontal treatment?
☐	☐	☐	Do you have headaches, earaches, or neck pain?	☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you ever had a bad reaction to dental anesthetic?	☐	☐	☐	Have you ever been told you grind your teeth?
☐	☐	☐	Does food catch between your teeth?	☐	☐	☐	Are you aware of your jaw clicking or popping?
☐	☐	☐	Have your teeth ever been bleached?	☐	☐	☐	Do you have dental implants?

MEDICAL INFORMATION

Physician Name_____ Date of last visit_____ Condition Treated_____

Yes	No	Don't Know	
☐	☐	☐	Are you taking any medications including non-prescription medications? If so what are you taking? _____
☐	☐	☐	Are you in good health? If any changes in your general health within the past year please describe: _____
☐	☐	☐	Are you taking, or have you taken any diet drugs? (Pondimin, Redux, Phen-fen)
☐	☐	☐	Do you use tobacco (smoking, snuff, chew)? Frequency and amount: _____
☐	☐	☐	Do you wear contact lenses?
☐	☐	☐	Are you pregnant? Due Date: _____ Nursing? _____ Birth Control Pills? _____
☐	☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when? _____

Allergies:

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Local Anesthetics	☐	☐	☐	Latex
☐	☐	☐	Aspirin	☐	☐	☐	Iodine
☐	☐	☐	Penicillin or other antibiotics _____	☐	☐	☐	Hay Fever / Seasonal
☐	☐	☐	Barbiturates, sedatives or sleeping pills _____	☐	☐	☐	Animals
☐	☐	☐	Sulfa drugs	☐	☐	☐	Codeine or other narcotics _____

To yes responses, specify type and reaction _____

Please (x) if you have or had any of the following diseases or problems.

Y	N	Don't Know		Y	N	Don't Know		Y	N	Don't Know	
☐	☐	☐	Abnormal Bleeding	☐	☐	☐	Chest pain upon exertion	☐	☐	☐	Migranes
☐	☐	☐	AIDS or HIV infection	☐	☐	☐	Chronic pain	☐	☐	☐	Night Sweats
☐	☐	☐	Anemia	☐	☐	☐	Persistent diarrhea	☐	☐	☐	Neurological disorders
☐	☐	☐	Arthritis	☐	☐	☐	Disease, drug or radiation-				If yes, specify:
☐	☐	☐	Rheumatoid arthritis				induced immunosurpression	☐	☐	☐	Osteoporosis
☐	☐	☐	Asthma	☐	☐	☐	Diabetes (specify type)	☐	☐	☐	Persistent swollen neck glands
☐	☐	☐	Blood transfusion				☐ Type I (insulin dep)	☐	☐	☐	Respiratory problems
			Date: _____				☐ Type II				☐ Emphysema
☐	☐	☐	Cancer / Chemo / Radiation	☐	☐	☐	Dry Mouth				☐ Bronchitis
☐	☐	☐	Cardiovascular Disease	☐	☐	☐	Eating Disorder	☐	☐	☐	Severe headaches
			☐ Angina				If yes, specify type:	☐	☐	☐	Severe or rapid weight loss
			☐ Arteriosclerosis	☐	☐	☐	Epilepsy	☐	☐	☐	Sexually transmitted disease
			☐ Artificial heart valves	☐	☐	☐	Fainting spells or seizures	☐	☐	☐	Sinus trouble
			Date: _____		☐	☐	G.E. Reflux	☐	☐	☐	Sleep disorder
			☐ Coronary insufficiency	☐	☐	☐	Glaucoma	☐	☐	☐	Sores or ulcers in the mouth
			☐ Coronary occlusion	☐	☐	☐	Hemophilia	☐	☐	☐	Stroke
			☐ Damaged heart valves	☐	☐	☐	Hepatitis / Jaundice / Liver disease	☐	☐	☐	Systemic lupus erythematosus
			☐ Heart Attack	☐	☐	☐	Recurrent infections	☐	☐	☐	Thyroid problems
			☐ Heart Murmur				If yes, specify type:	☐	☐	☐	Tuberculosis
			☐ High blood pressure	☐	☐	☐	Kidney problems	☐	☐	☐	Ulcers
			☐ Inborn heart defects	☐	☐	☐	Low blood pressure	☐	☐	☐	Excessive Urination
			☐ Mitral valve prolapse	☐	☐	☐	Mental health disorders	☐	☐	☐	Do you have any disease?
			☐ Pacemaker				If yes, specify type:				If yes, specify:
			☐ Rheumatic heart disease	☐	☐	☐	Malnutrition				

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature required_____ Date_____