Patient Information

Date_____

Patient's First Name_____Last Name_____ Middle Initial_____

Prefers to be called_____ Date of birth_____ Sex ◯ Male ◯ Female

☐ Married ☐ Single ☐ Minor ☐ Widowed ☐ Divorced

Email address_____ Employer_____Occupation_____

Home address_____ City, State, Zip Code_____

Home phone (___)_____Cell Phone (___)_____

Would you like to receive text reminders for your appointments? ◯ Y ◯ N

In case of emergency contact (Name, Relationship, Phone #)_____

Dental Insurance and Guarantor

Who is financially responsible for this account?_____ Relationship to patient_____

Primary Policy Holder's full name_____Date of Birth_____

Social Security # (for Insurance purposes only, some Insurance companies us this in place of subscriber ID)_____

Employer_____ Insurance Company_____

Subscriber # or Member ID_____Group #_____

Insurance Company Address and Phone #_____

Secondary Dental Coverage (if applicable)

Secondary Policy Holder's Full Name_____Date of Birth_____

Social Security # (see above)_____ Relationship to Patient_____

Employer_____ Insurance Company _____

Subscriber # or Member ID_____ Group # _____

Insurance Company Address and Phone #_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Podratz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above -named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian Date

_____ _____

Please Print Name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Dental History

Reason for today's visit_____ Date of last dental care_____

Former Dentist/Location_____ Date of last dental x-rays_____

Check (✓) if you have had problems with any of the following

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to hot
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal Treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush? _____

Medical History

Physician's Name_____ Date of last visit_____

Have you ever taken a group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? _____ If yes, describe_____

Have you every had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) If you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of breath
☐ Artificial Heart Valves	☐ Cough up blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal Disease

Medications

List medications you are currently taking:

_____

_____

Pharmacy Name_____

Phone (____)_____

Allergies

☐ Aspirin	☐ Sulfa
☐ Barbiturates (sleeping pills)	☐ Latex _____
☐ Codeine	☐ Other_____
☐ Local Anesthetic	
☐ Penicillin	

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____