Welcome

"Your personal dental care is our highest priority"

advanced DENTAL WELLNESS

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PATIENT INFORMATION

Name:_____ Today's date:_____

Birthdate:_____ Age:_____ Sex: ____M ____F Social Security Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

E-mail:_____

E-mail Communication _____Yes _____ No **Text Message** Communication _____Yes _____ No

Marital status: ____Married ____Single ____Widowed ____Divorced ____Separated ____Minor ____Partnered

Whom may we thank for referring you? _____

Emergency contact: _____ Relationship: _____ Phone: _____

RESPONSIBLE PARTY

_____ Same as above

Person Responsible for Account: _____ Relationship to patient: _____

Birthdate: _____ Social Security Number: _____ Employer: _____

Address:_____ City:_____ State:_____ Zip:_____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

INSURANCE INFORMATION

Name of Subscriber: _____ Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____ EMPLOYER: _____

Employer Address:_____

INSURANCE COMPANY: _____ Group # _____

Insurance Company Address _____

ADDITIONAL INSURANCE (Secondary)

Name of Subscriber: _____ Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____ Employer: _____

Employer address:_____ City:_____ State:_____ Zip:_____

Work phone: (_____)_____ Insurance company: _____ Group # _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care_____

Former dentist_____ Date of last dental x-rays_____

Address_____

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 growth in mouth

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

MEDICAL HISTORY

Have you ever been hospitalized or had a major operation?_____ If yes, describe:_____

Are you taking any medications, pills, or drugs? _____ Please list: _____

Are you taking a bone replacement drug? _____ If yes, name:_____

Are you allergic to any of the following? _____Aspirin _____Penicillin _____Sulfa _____Codeine

_____Acrylic _____Metal _____Latex _____Local Anesthetics _____Other: please specify_____

Do you use tobacco? _____ If yes, describe type, times/day, for how many years:_____

WOMEN: Are you… Pregnant/trying to get pregnant? ___Yes ___No

Taking oral contraceptives? ___Yes ___No Nursing? ___Yes ___No

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

___AIDS/HIV Positive	___Cold sores/fever blisters	___Heart Murmur	___Lung Disease
___Alzheimer's Disease	___Congenital Heart Disorder	___Heart Pacemaker	___Mitral Valve Prolapse
___Anemia	___Cortisone Medicine	___Heart Trouble/Disease	___Radiation Treatments
___Arthritis	___Diabetes	___Hepatitis A	___Renal Dialysis
___Artificial Heart Valve	___Emphysema	___Hepatitis B or C	___Rheumatic Fever
___Artificial Joint	___Epilepsy/Seizures	___High Blood Pressure	___STD
___Asthma	___Excessive Bleeding	___Hypoglycemia	___Sinus Trouble
___Blood Transfusion	___Fainting/Dizziness	___Irregular Heartbeat	___Stroke
___Cancer	___Frequent Headaches	___Kidney Problems	___Swelling of Limbs
___Chemotherapy	___Glaucoma	___Leukemia	___Thyroid Problems
___Chest Pains	___Heart Attack/Failure	___Low Blood Pressure	___Tonsillitis
			___Tuberculosis

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Raisch 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 dentist 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.

Signature:_____ Date: _____

Print name: _____

Payment is due in full at time of treatment unless prior arrangements have been approved.