Welcome To Dentistry by RSE

PATIENT INFORMATION

Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ Primary Care Doctor _____

Driver's Lic.# _____ Who may we thank for referring you? _____

Employer _____ Bus. Tel.(_____) _____ Ext. _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

Who will be responsible for your account?

(If self, skip to next section) ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.(_____) _____

Spouse or other guarantor information (*if different from above*)

Name _____ Relation _____ S.S.# _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION

Student: ❑ Full Time ❑ Part Time ❑ Not School Name/Address _____

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single _____

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not

PRIMARY INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

Tel.(_____) _____ S.S. # _____

I.D. # _____

SECONDARY INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

Tel.(_____) _____ S.S. # _____

I.D. # _____

Fees and Payments

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X _____ **Date:** X _____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X _____ **Date:** X _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X _____ **Date:** X _____

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ No Are you under the care of a physician? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No If Yes, please explain_____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	**High blood pressure**	❑	❑	**Respiratory problems**	❑	❑	**A history of alcohol abuse**	❑	❑	**Convulsions / Epilepsy**
❑	❑	**Low blood pressure**	❑	❑	**Tuberculosis**	❑	❑	**Jaundice / Liver disease**	❑	❑	**Contagious disease**
❑	❑	**Chest pain / Angina**	❑	❑	**Emphysema**	❑	❑	**Hepatitis**	❑	❑	**Other**_____
❑	❑	**Heart attack(s)**	❑	❑	**Do you smoke / Vape**	❑	❑	**HIV / AIDS**			
❑	❑	**Stents**	❑	❑	**Do you use chewing tobacco**	❑	❑	**Arthritis / Joint disease**			
❑	❑	**Irregular heart beat / Afib**	❑	❑	**Blood disorder**	❑	❑	**Kidney trouble**			
❑	❑	**Cardiac pacemaker**	❑	❑	**Bruise easily**	❑	❑	**Are you on dialysis**			
❑	❑	**Heart surgery**	❑	❑	**Abnormal bleeding / Clotting**	❑	❑	**Tumor**			
❑	❑	**Damaged heart valves**	❑	❑	**Anemia**	❑	❑	**Radiation / Chemotherapy**			
❑	❑	**Prosthetic Heart Valve**	❑	❑	**Stroke**	❑	❑	**Immune system problems**			
❑	❑	**Swollen ankles**	❑	❑	**Thyroid trouble**	❑	❑	**Parkinson's Disease**			
❑	❑	**Bronchitis / Chronic cough**	❑	❑	**Diabetes**	❑	❑	**Alzheimer's / Dementia**			
❑	❑	**Asthma**	❑	❑	**Delay in healing**	❑	❑	**Mental health problems**			
❑	❑	**Hay fever / Sinus problems**	❑	❑	**Stomach ulcers**	❑	❑	**Eye disease / Glaucoma**			
❑	❑	**Snoring / Sleep apnea**	❑	❑	**A history of drug abuse**	❑	❑	**Fainting spells**			

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

Y	N		Y	N		Y	N		Y	N	
❑	❑	**Nerve pills**	❑	❑	Pain killers	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	**Blood thinners (Coumadin)**	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
❑	❑	**Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)**									

PLEASE LIST ANY OTHER MEDICATION(S) YOU ARE TAKING, AND WHY:

_____

_____

_____

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	**Penicillin / Amoxicillin**	❑	❑	**Clindamycin**	❑	❑	**Local anesthetic (numbing med)**	❑	❑	**Latex**
❑	❑	**Valium or other tranquilzers**	❑	❑	**Aspirin**	❑	❑	**Codeine or other narcotics**			

Please list any other medication or antibiotic you are allergic to:

_____

_____

Please list any allergies other than drug allergies:

_____

_____

1-4 below for women only: *(women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No **2)** Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No **4)** Are you taking birth control pills: ❑ Yes ❑ No

DENTAL INFORMATION

Reason for today's visit: _____ Are you in pain? ❑ Yes ❑ No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

- ❑ Discomfort, clicking, or popping in jaw
- ❑ Difficulty closing jaw
- ❑ Difficulty opening jaw
- ❑ Teeth grinding / clenching
- ❑ Ringing in ears
- ❑ Lost / broken filling(s)
- ❑ My teeth are sensitive to:
  - ❑ Hot ❑ Cold ❑ Sweets ❑ Biting
- ❑ Broken / chipped tooth
- ❑ Loose / shifting teeth
- ❑ Food caught between teeth
- ❑ Red, swollen, or bleeding gums
- ❑ Gum disease
- ❑ Other:_____
- ❑ Stained teeth
- ❑ Bad breath
- ❑ Dry Mouth
- ❑ Burning tongue / lips
- ❑ Swelling / lumps in mouth
- ❑ Blisters / sores in or around the mouth
- ❑ Recent infections or sore throat
- ❑ A removal dental appliance
- ❑ Prolonged bleeding from an injury / extraction

Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

What type of tooth bristles do you use? ❑ Soft ❑ Medium ❑ Hard How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Is there anything about your smile you would like to change? ❑ Yes ❑ No If Yes, please explain: _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X