Barth
DENTAL CARE

Patient Information

Name: _____ Date: _____

Home Phone: _____ Cell Phone: _____

Preferred number to reach you and best time: _____

Email Address: _____

Birthdate: _____ Social Security # _____

Address: _____

Single Married Partnered Divorced Widowed

Spouse's Name: _____

Your Employer: _____

Employer Address: _____

Employer Phone: _____

Occupation: _____

Other family members seen by us: _____

Referred to us by: _____

Previous Dentist: _____

Primary Insurance Information

Dental Coverage: Yes No

Insurance Name: _____

Insurance Address: _____

Insurance Phone: _____

Group or Policy No. _____

Insured's Name: _____ Insured's Birthdate: _____

Insured's Employer: _____

Employer Address: _____

Secondary Insurance Information

Do you have a secondary insurance plan? Yes No

Insurance Name: _____

Insurance Address: _____

Insurance Phone: _____

Group or Policy No. : _____

Insured's Name: _____

Insured's Birthdate: _____

Insured Employer: _____

Employer Address: _____

Patient Medical History

Primary Physician: _____

Office Address: _____

Office Phone: _____

Date of last visit: _____

Your current health is: Good Fair Poor

Are you under the care of a physician? Yes No
If yes, please describe: _____

Do you smoke or use tobacco in any form? Yes No

Have you had metal rods, pins, or implants? Yes No

Are you taking prescription medication? Yes No Please list: _____

Are you taking over the counter medication? Yes No Please list: _____

Have you ever taken Phen Fen, Redux, or Pondimin? Yes No If so, when? _____

Have you ever taken Fosamax, Actonel, Boniva, Aredia, or other bisphosphate? Yes No

Women: Are you taking a prescription for birth control? Yes No

Are you pregnant or nursing? Yes No

Have you ever had any of the following medical problems?

Abnormal bleeding, hemophilia
AIDS
Alcohol or drug abuse
Anemia
Arthritis
Artificial Bones, joints, valves
Asthma
Blood transfusion
Cancer, chemotherapy
Colitis
Congenital heart defect
Diabetes
Difficulty breathing
Emphysema
Epilepsy
Fainting
Glaucoma
Hay Fever
Heart attack, heart surgery
Heart murmur
Hepatitis
Herpes, fever blisters
High blood pressure
HIV
Hospitalized for any reason
Kidney problems
Liver disease
Low blood pressure
Lupus
Mitral valve prolapse
Pacemaker
Psychiatric problems
Radiation treatment
Rheumatic or scarlet fever
Seizure
Shingles
Sickle cell disease, traits
Sinus problems, Stroke, Thyroid problems
Tuberculosis
Ulcers
Venereal disease

Please list any serious medical conditions:

Are you allergic to the following?

Aspirin
Codeine
Dental Aesthetics
Erythromycin
Jewelry, metals
Latex
Penicillin
Sulfur
Tetracycline

Please list any other drug allergies: _____

Patient Dental History

What is the reason for your visit today? _____

Are you in pain? Yes No

Do you require antibiotics before treatment? Yes No

Your current dental health is: Good Fair Poor

Have you ever had a serious problem associated with dental work? Yes No

Do you floss daily? Yes No

Do you brush daily? Yes No

Have you ever had gum treatment? Yes No

Do your gums bleed? Yes No

Have you ever had periodontal disease? Yes No

Do you have jaw pain (TMJ?) Yes No

Are your teeth sensitive to heat or cold? Yes No

Do you have any loose teeth? Yes No

Do you have wisdom teeth? Yes No

Are you happy with your smile? Yes No

If not, what would you change?

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information is held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical or dental history. I authorize the staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature: _____ Date: _____

Payment

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

I understand I am responsible for payment of services rendered and also for paying any co payment or deductible that my insurance does not cover. I hereby uthorize payment of dental benefits directly to Barth Dental Care. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including diagnosis and records of reatment or examinations, to my insurance company.

Signature: _____ Date: _____

Barth Dental Care is HIPPA compliant and dedicated to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.