

# ROCKVILLE DENTAL ARTS

## PATIENT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address \_\_\_\_\_ SSN# \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If Patient is a student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## RESPONSIBLE PARTY

Name of Person responsible for this account \_\_\_\_\_ Relation to patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Currently a patient in our office?  Yes  No

## INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## ADDITIONAL INSURANCE

Name of Insured \_\_\_\_\_ Relation to patient \_\_\_\_\_

Date of birth \_\_\_\_\_ SSN# \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

Address \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bad breath                        | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to heat     |
| <input type="checkbox"/> Bleeding gums                     | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets   |
| <input type="checkbox"/> Clicking or popping jaw           | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between the teeth |   | <input type="checkbox"/> Sensitivity to cold     |
| <input type="checkbox"/> Sores or growths in your mouth    |   |  |

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No if yes, describe \_\_\_\_\_

Have you ever had 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 had any of the following:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough Persistent     | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet fever              |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habits             |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Hyperlipidemia       | <input type="checkbox"/> Radiation             | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |

**MEDICATIONS**

**ALLERGIES**

List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I have read and answered the above questions to the best of my knowledge. I authorize and request insurance company to pay directly to the dentist or dental insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Signature of patient or parent (if minor)

\_\_\_\_\_  
Date