



PATIENT INFORMATION:

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST, FIRST M.I.

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Gender: Male:  Female:

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Name and # \_\_\_\_\_

Has any member of your family been treated in our office?: \_\_\_\_\_

DENTAL INSURANCE INFORMATION:

Primary Policy:

Name of Insured: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
LAST, FIRST M.I.

Employer: \_\_\_\_\_ Insurance Co: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Group #: \_\_\_\_\_  
ID#: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Secondary Insurance (if applicable):

Name of Insured: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
LAST, FIRST M.I.

Employer: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Group #: \_\_\_\_\_  
ID#: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

DENTAL HISTORY

Reason for today's visit?

Date of last dental visit? \_\_\_\_\_

Did you bring x-rays?  YES  NO

How do you rate your dental health?  Good  Fair  Poor

Do your gums bleed when you brush or floss?  Yes  No

Do you own an electric toothbrush?  Yes  No

Do you smoke or use chew tobacco?  Yes  No

*Please check if you have or do any of the following:*

- |                                                        |                                                  |                                           |
|--------------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Sensitivity to Biting   | <input type="checkbox"/> Dry Mouth        |
| <input type="checkbox"/> Blisters on Lips/Mouth        | <input type="checkbox"/> Sensitivity to Sweets   | <input type="checkbox"/> Missing Teeth    |
| <input type="checkbox"/> Clicking/Popping of Jaw       | <input type="checkbox"/> Sensitivity to Hot/Cold | <input type="checkbox"/> Sores or Growths |
| <input type="checkbox"/> Clenching of Teeth            | <input type="checkbox"/> Jaw Pain                | <input type="checkbox"/> Mouth Breathing  |
| <input type="checkbox"/> Grind Teeth                   | <input type="checkbox"/> Ear Pain                | <input type="checkbox"/> Suck Your Thumb  |
| <input type="checkbox"/> Broken/Loose Teeth or Filling | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Food Collection  |

Have you been treated for any of the following?

- Orthodontics  Periodontal Disease  Grinding
- Do you experience dental anxiety?  Yes  No

Do you have any allergies or have you had any bad reactions to:

- Local Anesthetic
- Antibiotics \_\_\_\_\_
- Latex
- Other \_\_\_\_\_

**MEDICAL HISTORY**

Are you under physician's care?     Yes     No    If yes, for what? \_\_\_\_\_

Physician's name: \_\_\_\_\_

Physician's #: \_\_\_\_\_

**Please list medications and other pills you are taking:**

Do you generally take antibiotics before a dental visit?     Yes     No

*Please check any and all that you have had: (indicate date if possible)*

- |                                                  |                                               |                                             |                                        |
|--------------------------------------------------|-----------------------------------------------|---------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Glaucoma      |
| <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Thyroid Problems     | <input type="checkbox"/> Radiation          | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Shingles           | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Psychiatric Issues   | <input type="checkbox"/> Chemotherapy       | <input type="checkbox"/> Hepatitis     |
| <input type="checkbox"/> Heart Murmurs           | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Blood Disorders         | <input type="checkbox"/> HIV/Aids             | <input type="checkbox"/> Epilepsy /Seizures | <input type="checkbox"/> Sleep Apnea   |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Major Surgery      |                                        |
| <input type="checkbox"/> Fainting or Dizziness   | <input type="checkbox"/> Bleeding/Clotting    | <input type="checkbox"/> Artificial Joints  |                                        |

Are there any other medical issues or conditions not listed that we should know about?

Females: Are you pregnant or trying to get pregnant?     Yes     No

Are you nursing?     Yes     No

Please certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in medical status.

**Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_**

CONSENT FOR TREATMENT:

1. I hereby authorize Doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed necessary to make a thorough diagnosis of dental needs.
  
2. Upon such diagnosis, I authorize the Doctor and/or Hygienist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am aware that this office provides optimal care as recommended by the ADA and my dental insurance may not cover certain procedures. It is my responsibility to be aware of what is covered by my insurance.
  
3. I agree to the use of anesthetics and other medications as necessary. I fully understand that the use of said agents imposes certain risks and realize that it is necessary to inform the doctor and staff of any drugs, including recreational drugs that I may be taking in order to minimize these risks.

Patient or Guardian (Printed): \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL AND OTHER POLICIES:

I understand that payments for all services are to be paid at the time of service unless different payment arrangements are made in advance. We will work with you if we have confirmed dental insurance and collect only the estimated copayment at the time of service. We make no guarantee that the amount we collect is accurate. We estimate the collected copayment from historical data. If you want a more accurate estimate, ask to have a pretreatment estimate to your insurance company. We will gladly submit your insurance claim to the insurance address you gave us. Once we reach your annual maximum benefit, we will look to you for complete payment at the time of service unless a different payment arrangement has been made. We accept cash, checks, money orders and all major credit cards for your payments.

In accordance with HIPAA, I agree to the disclosure of my protected health information to my insurance company. I authorize my insurance company to pay Geyer Dental Group directly.

I have read the above Financial and Other Policies and agree to the content.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_