Patient Information

Patient's Name: _____ _____
First Last

Spouse's Name or Parent's Name for child patients:

_____

Patient's\Parent Street Address:

_____

City: _____ State: _____ Zip Code: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

Patient's Drivers License Number: _____

Patient's Home Telephone: ( ) _____

Cell Phone: ( ) _____

Patient's Employer: _____

Employer's Telephone: ( ) _____

Emergency Contact Person: _____

E-mail address: _____

DENTAL HISTORY:

Previous dentist's name:_____ city _____ telephone _____

How long has been since you have seen a dentist? _____

Date of last complete dental exam _____

Date of last full mouth x-rays _____

Are you having a dental problem now? __ yes __ no Describe: _____

Do you wear DENTURES? (Partial or full) yes no

Are you UNHAPPY with them? yes no

Have you had any PERIODONTAL (gum) treatments? yes no

Do your gums BLEED, feels TENDER, or feel IRRITATED? yes no

Are your teeth SENSITIVE to hot, cold, sweets, biting pressure? yes no

Are you unhappy with the APPEARANCE of your teeth? yes no

Are you aware of GRINDING or CLENCHING your teeth? yes no

Do you have HEADACHES, EAR ACHES, or NECK PAINS? yes no

Do you have LOOSE, TIPPED, or SHIFTING TEETH? yes no

Have you had BRACES (sees orthodontics)? yes no

Do you have DISCOLORED TEETH that bother you? yes no

Would you like your SMILE to look better or different? yes no

Do you have problems with fillings or teeth BREAKING? yes no

Do use it DENTAL FLOSS daily? yes no

Are you aware of any ALLERGIES or ADVERSE REACTIONS to any substances or medicines? yes no

Describe:_____

MEDICAL HISTORY:

Do you have any current health problems? yes no

Are you under the care of a physician? yes no

What for:_____

Are you taking any medication? yes no

List:_____

Are you pregnant? yes no Due date _____

Do you use tobacco products? yes no

Family physician's name, address, telephone:

_____

_____

_____

Please enter the names of other persons that you would like us to share your confidential medical information with. We are unable to discuss or release any information or materials to any persons beside you unless they are listed here.

Names: _____

_____

Your signature; _____ date _____

Circle conditions that you have or have had:

heart attack
heart disease
angina
high blood pressure
heart murmur
rheumatic fever
artificial heart valves
heart surgery
artificial joint
anemia
stroke
kidney disease
ulcers
cosmetic surgery
hepatitis A
hepatitis B
hepatitis C
liver disease
jaundice
blood transfusion
drug addiction
hemophilia
fever blisters
epilepsy or seizures
fainting or dizzy spells
nervousness
psychiatric treatment
sickle cell disease
glaucoma
chemotherapy-cancer
venereal disease
tuberculosis (TB)
asthma
hay fever
sinus trouble
allergies or hives
diabetes
thyroid disease
radiation treatment
arthritis
rheumatism
cortisone therapy
jaw joint pain
alcoholism
bleeding problems
AIDS
bruising
emphysema

I have answered these questions truthfully to the best of my ability:

Signature: _____ date _____

Dental Insurance Information

Please read and sign:

I, _____ (print name) allow release of information regarding my dental claims with this office. I hereby authorize payment of dental benefits directly to this office. I also understand that the payment for dental services is my responsibility. This office files for and accepts payments from my insurance company on my behalf but I am ultimately responsible for payment of all balances that are due and/or uncovered or partially covered by my insurance.

This form remains in effect unless revoked by me in writing to this office of David J. Streng, D.D.S.

Signature (seal) _____

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We must have all of this information in order to process your insurance:

Check one: ____ Primary Carrier ____ Secondary Carrier (Dual Coverage)

Name of insured person: _____
Address of insured: _____
Date of birth of insured: _____
Social security number of insured: _____
Patient's relationship to the insured: ___ Self ___ Spouse ___ Child
Name of insured's employer: _____
Address of employer: _____

Insurance company name: _____
Insurance company address: _____
_____
Dental insurance GROUP NUMBER: _____
Must have this number!!

If you have Dual Insurance Coverage, please complete another form just like this and check **Secondary Carrier**.