

About You

Date _____

Patient's Name: _____
First MI Last I Like To Be Called

Address: _____
Street City State Zip

Cell Phone _____ Home Phone _____ Email Address _____

Date of Birth _____ Your Age Today _____ Social Security # _____

If patient is a minor, please provide name of parent or guardian: _____

Whom may we thank for referring you? _____

Marital Status: _____

Emergency Contact

Name _____ Relation To You _____

Cell Phone _____ Home Phone _____

Electronic Communications

I agree that Reichel Dental may communicate with me electronically at the email and/or cell phone provided, and that I can withdraw my consent for electronic communications by calling the office.

Patient Signature: _____ Date _____

Dental Benefit Information

Primary Insurance Coverage

Insurance Co. Name: _____ Phone _____ Group # _____

Insurance Co. Address: _____

Subscriber First Name _____ MI _____ Last Name _____

Relationship to Patient _____ Date of Birth _____ SSN _____

Insurance Employer _____ Employer's Address _____

Secondary Insurance Coverage

Insurance Co. Name: _____ Phone _____ Group # _____

Insurance Co. Address: _____

Subscriber First Name _____ MI _____ Last Name _____

Relationship to Patient _____ Date of Birth _____ SSN _____

Insurance Employer _____ Employer's Address _____

Dental History

Why have you come to Dr. Reichel's office today? _____

How many times a day do you brush? _____

Do you floss daily? Yes No

Are you currently in pain or discomfort with your teeth?
 Yes No

Do your gums bleed? Yes No

If yes, please explain: _____

Have you ever had periodontal (gum) disease? Yes No

If yes, was it treated? When? _____

Have you experienced problems associated with any previous dental work?
 Yes No

Do you have mobility in your teeth? Yes No

If yes, please explain: _____

Are your teeth sensitive to hot, cold or sweet? Yes No

Do you require antibiotics before dental treatment?
 Yes No

Are your teeth sensitive to pressure? Yes No

How would you rate the condition of your teeth? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

How would you rate the condition of your gums? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

How important is it to you to keep your teeth and gums as healthy as possible? (not important) 1 2 3 4 5 6 7 8 9 10 (very important)

If you could wave a magic wand and change anything about the appearance of your smile, what would you want to do?

Medical History

Do you have a primary care physician? Yes No

Your current health is: Good Fair Poor

Physician's Name: _____

Please explain: _____

Phone: _____

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

Date of last visit: _____

If yes, please explain: _____

For Women:

Are you taking or on a form of birth control?

Unsure Yes No

Are you pregnant?

Yes No

Are you nursing?

Yes No

Are you allergic to any of the following?

Aspirin Y N

Latex Y N

Barbiturates Y N

Penicillin Y N

Codeine Y N

Sedatives Y N

Dental Anesthetics Y N

Sulfa Drugs Y N

Erythromycin Y N

Tetracycline Y N

Please list additional drugs/materials that cause allergic reactions: _____

Are you taking any of the following?

Acetaminophen Blood Thinners

Heart Medication Steroids/Cortisone

Antibiotics Blood Pressure Medication

Diabetes Drugs Thyroid Medicine

Antihistamines

Nitroglycerin

Aspirin Cold Remedies

Recreational Drugs

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins, or minerals not listed above? Y N

If yes, please list each one: _____

Do you need to take antibiotics before any dental work?

Yes

No

Do you or have you experienced the following?

Abnormal Bleeding

Acid Reflux

Alcohol Abuse

Anemia

Anxiety

Arthritis

Artificial Bones/Joints

Artificial Heart Valves

Asthma

Blood Transfusion

Cancer

Celiac Disease

Chemotherapy

Chicken Pox

Colitis

Congenital Heart Defect

Diabetes

Difficulty Breathing

Drug Abuse

Emphysema

Epilepsy

Fainting Spells

Fever Blisters

Glaucoma

Hay Fever

Headaches

Heart Attack

Heart Murmur

Heart Surgery

Hemophilia

Hepatitis

Herpes

High Blood Pressure

HIV+/AIDS

Hospitalized For Any Reason

Kidney Problems

Liver Disease

Low Blood Pressure

Lupus

Mitral Valve Prolapse

Osteoporosis

Pacemaker

Persistent Cough

Psychiatric Problems

Radiation Treatment

Rheumatic Fever

Seizures

Shingles

Sickle Cell Disease

Sinus Problems

Sleep Apnea

Steroid Therapy

Stroke

Thyroid Problems

Tonsillitis

Tuberculosis

Ulcers

Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

Authorizations

Dentist's Signature

Date

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

Patient/Guardian Signature

Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Reichel all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I realize this office bills my insurance company as a courtesy, however, I understand that I am ultimately responsible for any non-payment from my insurance company. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions, whether manual or electronic.

Patient/Guardian Signature

Date