REICHEL DENTAL

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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? _____

_____

_____

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

If yes, please explain: _____

_____

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

If yes, please explain: _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

How many times a day do you brush? _____

Do you floss daily? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

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

If yes, was it treated? When? _____

Do you have mobility in your teeth? ☐ Yes ☐ No

Are your teeth sensitive to hot, cold or sweet? ☐ 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

Physician's Name: _____

Phone: _____

Date of last visit: _____

Your current health is: ☐ Good ☐ Fair ☐ Poor

Please explain: _____

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

If yes, please explain: _____

For Women:

Are you taking or on a form of birth control?	☐ Yes	☐ No
Are you pregnant? ☐Unsure	☐ 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