Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex ❑ M ❑ F Marital Status ❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Divorced

May we contact you via email? ❑ Yes ❑ No E-mail _____

Social Security # _____ Cell Phone #1 (____) _____

Employer/School _____ Employer Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

BILLING INFORMATION

Name of Person Responsible For This Account _____ Relationship _____

Social Security # _____

Mailing Address *(If Different From Above)* _____

City _____ State _____ Zip _____ Phone (____) _____

INSURANCE INFORMATION

Name of Subscriber _____ Relation to Patient _____

Birthdate _____ Social Security # _____

Employer _____ Work Phone (____) _____

Insurance Company _____ Group # _____ ID # _____

Address _____ City _____ State _____ Zip _____

ADDITIONAL INSURANCE

Name of Subscriber _____ Relation to Patient _____

Birthdate _____ Social Security # _____

Employer _____ Work Phone (____) _____

Insurance Company _____ Group # _____ ID # _____

Address _____ City _____ State _____ Zip _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

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

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Jaw pain
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever been or are you currently being treated for a calcium deficiency / Osteoporosis? ☐ Yes ☐ No

Name of Medication _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

- ☐ Artificial Joints
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Back Problems
- ☐ Osteoporosis
- ☐ Arthritis, Rheumatism
- ☐ Abnormal Bleeding
- ☐ Hemophilia
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Blood Disease
- ☐ Circulatory Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Heart Problems
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Congenital Heart Defect
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Hepatitis A, B, C
- ☐ Diabetes
- ☐ IBS (Chron's/Colitis)
- ☐ Frequent Headaches
- ☐ Fainting Spells
- ☐ Seizures
- ☐ Stroke
- ☐ Neurological Disease
- ☐ Psychiatric Problems
- ☐ Alzheimer's/Dementia
- ☐ Difficulty Breathing
- ☐ Respiratory Disease
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Shingles
- ☐ Cortisone Treatment
- ☐ Cosmetic Surgery
- ☐ Glaucoma
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Chemical Dependency
- ☐ Alcohol/Drug Abuse
- ☐ Smoker
- ☐ Chew/Snuff
- ☐ STD/HPV
- ☐ HIV/ AIDS
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Prolonged Antibiotic Therapy

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Seasonal
- ☐ Other

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health. _____

Signature of Patient, Parent, Guardian or Personal Representative

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Name of Insurance Company(ies)

Reuben N. Pelot, III, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative *Date*

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative *Relationship to Patient*

Payment is due in full at time of treatment unless prior arrangements have been approved