WELCOME
TO THE OFFICE OF

GEBFERT-PARK
FAMILY DENTISTRY

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate the better we can care for you.

TODAY'S DATE:____________________

1. ABOUT YOU, THE PATIENT

Name:______________________________
I prefer to be called:______________________
Male_______ Female_______
Birthdate:______________ SS#______________
Marital Status:___________________________
Address:_________________________________
City:______________ State:___ Zip Code:_________
Home Phone #:____________________________
Cell/Other #:_____________________________
Email:___________________________________
Whom may we thank for referring you?:
____

2. DENTAL INSURANCE INFO

PRIMARY DENTAL INSURANCE

Insurance Co. Name:______________________
Insurance Co. Address:____________________
Insurance Co. Phone #:____________________
Group #:_________________________________
Subscriber Name:_________________________
Birthdate:____________ Subscriber ID:__________
Employer:________________________________

SECONDARY DENTAL INSURANCE

Insurance Co. Name:______________________
Group #:____________ Phone #:______________
Insured's Name:__________________________
Birthdate:____________ Subscriber ID:__________
Employer:________________________________

3. EMPLOYER INFORMATION

Company:_________________________________
Address:_________________________________
Work Phone #:____________________ Ext._____

4. SPOUSE INFORMATION

Name:___________________________________
Employer:________________________________
Work Phone #:____________________ Ext._____
Birthdate:______________ SS#______________

5. RESPONSIBLE PARTY

Name of person responsible for account:
____
Relationship to patient:____________________
Billing Address:__________________________
Home #:______________ Work #.______________
Employer:______________ SS#______________
Birthdate:________________________________

6. DENTAL HISTORY

Reason for Today's Visit:
____
Are your teeth sensitive to:
Cold Hot Sweets Biting
Does food collect between your teeth:___________
Have you ever had excessive bleeding after a dental extraction?____________________
Have you ever experienced pain or discomfort in your jaw joint (TMJ)?
____
Have you ever had a problem associated with any previous dental work?___________________
What do you like least about your teeth?
____
Have you ever considered having your teeth whitened?_______________________________
Last Dental Visit Date:______________________
Previous Dentist:___________________________

PLEASE COMPLETE BACKSIDE

6. MEDICAL HISTORY

Name of Physician:________________________ Date of last Physical Exam:____________

Are you currently under the care of a physician?:____________

If so, what is the condition being treated?:____

Have you had any serious illness, operation, or been hospitalized in the past 5 years?:______________

If so, for what?:____________________________

Are you taking any prescription/over-the-counter medicines?:_______ Please list each one:__________

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Are you allergic to any of the following?: *(circle those that apply)*

Penicillin Tetracycline Aspirin Erythromycin Codeine Nickel Latex Dental Anaesthetics

Other Antibiotics (please list):____

Please list any other allergies that you are aware of (foods, drugs, pollens, etc):_______________

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<u>FOR WOMEN:</u>

Are you taking birth control pills?:____________ Are you pregnant?____________

To your knowledge, have you ever had any of the following medical conditions?: (circle those that apply)

Artificial Joints
Replacement Date:______
Abnormal Bleeding
AIDS, HIV Positive, ARC
Arthritis
Diabetes
Ear or Eye Problems
Epilepsy
Blood Transfusion
Drastic Weight Change
Severe/Frequent Headaches

Abnormal Blood Pressure
Heart Attack
Stroke
Mitral Valve Prolapse
Rheumatic Fever
Fainting Spells, Seizures
Chemotherapy
Venereal Disease
Heart Murmur
Congenital Heart Defect

Hepatitis
Kidney, Urinary or Bladder Problems
Nervous or Mental Disorders
Respiratory Disease or Tuberculosis
Radiation Therapy
Asthma
Ulcers/Colitis

If you circled any of the above, please explain:____________________________________

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If you have any disease, condition, or problem not listed above, please explain:_______________

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I realize that my insurance company, if any, has an obligation to me and not to the dentist. This office has no contractual arrangement with insurance carriers, therefore I am responsible to this office for payment of services rendered. I authorize this dental staff to perform any necessary dental services with my informed consent that I need during diagnosis and treatment.

SIGNATURE____________________________ DATE______________________

OFFICE USE ONLY------MEDICAL HISTORY UPDATE

DATE COMMENTS____

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