

**PERSONAL HISTORY**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Sex: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ e-Mail: \_\_\_\_\_

Spouse or Parent's Name (if child): \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Purpose of Call: \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_ **GENERAL DENTIST:** \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PERSON**

*(If patient is a minor – under 18 years of age)*

Responsible Person: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Day Phone: \_\_\_\_\_

SS: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**Primary Coverage:** Employee Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employee I.D. \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Group: \_\_\_\_\_ Relationship to Policy Holder (*Self, Spouse, Child*): \_\_\_\_\_

**Secondary Coverage:** Employee Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employee I.D. \_\_\_\_\_ SS# \_\_\_\_\_

2<sup>nd</sup> Insurance Co. Name: \_\_\_\_\_

2<sup>nd</sup> Insurance Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Group: \_\_\_\_\_ Relationship to Policy Holder (*Self, Spouse, Child*): \_\_\_\_\_

MEDICAL HISTORY



1. Date of last medical exam \_\_\_\_\_
2. Please list any medications you are currently taking \_\_\_\_\_  
\_\_\_\_\_
3. Are you currently under a physician's care? \_\_\_\_\_ If so, reason for treatment \_\_\_\_\_  
\_\_\_\_\_
4. Please circle any illness that you have had or currently have:  

Allergies	Diabetes	Asthma	Cancer
Tuberculosis	Rheumatic fever	Epilepsy	Radiation treatment
Anemia	Hepatitis	Glaucoma	Kidney or Liver
Heart Trouble	HIV/AIDS	Other _____	
5. Have you ever had trouble with prolonged bleeding after surgery? \_\_\_\_\_
6. Have you had joint surgery or joint replacement? \_\_\_\_\_
7. Do you have a pacemaker? \_\_\_\_\_
8. Have you ever had any unusual reaction to an anesthetic or drug (like penicillin)? \_\_\_\_\_
9. Have you ever had an unusual or allergic reaction to products containing **LATEX**? \_\_\_\_\_
10. Do you have a heart murmur? \_\_\_\_\_
11. Is there any other information that should be known about your health or about previous dental visits? \_\_\_\_\_

I understand that the patient (parent or guardian) is fully responsible for total payment of services performed in this office including any amounts not covered by any health insurance. Payment is required when professional services are rendered unless other arrangements have been made in advance. Balances over thirty (30) days will be subject to a 1-1½% service charge per month (minimum \$1.00). If the account is turned over for legal collection, the patient (parent or guardian) is also responsible for all costs of collection plus reasonable attorney fees which shall be deemed to be 33% of the balance owed, with a minimum attorney fee of \$450.00. If you have any questions, please do not hesitate to ask the staff or doctor.

**Office Policy Regarding Insured Patients**

**Our office is a participating provider within a few insurance networks. Most insurance plans do not consider the services performed in our office as 100% covered benefits. As a service to our patients, we may elect to accept an "estimated co-payment" for services rendered at the time of treatment, in lieu of our full fee. The patient understands that this is a service offered for his/her convenience and is not a guarantee of benefits. The patient is responsible for any balance remaining after the claim is considered. I, the patient (parent or guardian), authorize payment of dental benefits to Dr. John S. Ehreth.**

Patient \_\_\_\_\_  
 \*Parent \_\_\_\_\_  
 Guardian \_\_\_\_\_

**MEDICAL UPDATE**

Date: \_\_\_\_\_ No change since last date \_\_\_\_\_  
 Date: \_\_\_\_\_ No change since last date \_\_\_\_\_