

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# _____

2nd Insurance Co. Name: _____

2nd 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 _____