coombs&ross
FAMILY DENTISTRY LLC

Patient Information

Patient Name: _____ Date: _____

○ Male ○ Female ○ Married ○ Single ○ Other

Social Security #:_____-_____-_____ Birth Date: _____ Age: _____

Phone: (Home): _____ (Work): _____ (Cell): _____

Preferred method of confirming appointments: O cell O home O work O email

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about our office? : _____

Responsible Party and Insurance Information

Person Responsible for this Account**:** _____

Responsible Party's Address: _____

City: _____ State: _____ Zip: _____

Responsible Party's Social Security Number: _____-_____-_____

Insurance Guarantor's name: _____ Relationship to Patient: _____

Guarantor's Employer: _____

Guarantor's Date of Birth: _____ Guarantor's Social Security Number: _____-_____-_____

***Please present a copy of the dental insurance card ***

Name of Dental Insurance: _____ Policy Number: _____

Group Number: _____

Medical History

Patient's Name: _____ Today's Date: _____

Date of last Dental Visit: _____ Medical Doctor: _____

Are you under a physician's care now? O YES O NO If so, for what reason? _____

List all medications you are currently taking

_____

_____

_____

Have you ever had any of the following or currently have any of the following? Please check all that apply:

- o Aids/HIV
- o Allergies
- o Anemia or blood disorders
- o Tuberculosis
- o Artificial Joints
- o Asthma
- o Blood Disease
- o Cancer
- o Diabetes
- o Dizziness
- o Fainting
- o Epilepsy
- o Seizures
- o Glaucoma
- o Persistent Cough
- o Heart Trouble
- o Emphysema
- o Hemophilia
- o Stomach Ulcers
- o Herpes or Fever blisters
- o Hepatitis
- o High/low Blood Pressure
- o Pregnant? If so, Due Date: _____
- o Antibiotic Premed for Dental Appointments
- o Rheumatic fever
- o Heart Murmur
- o Damaged Heart Valves
- o Allergic Reaction to Dental Anesthetics
- o Prolonged bleeding after surgery or extractions

Do you use tobacco products? o YES o NO

Would you like to provide any additional information about your health or previous dental visits?

_____

_____

_____

Your appointment time is valuable and has been reserved specifically for you. If it is necessary to cancel or reschedule your appointment, we kindly ask that you give us 24 hour notice. Otherwise a fee of $50 may be incurred.

I understand that my dental insurance is a contract between me and my insurance company. I understand that I am fully responsible for charges that my dental insurance denies or does not cover. We are unable to file secondary insurance but can assist you in filing it yourself.

To the best of my knowledge, all of the preceding answers and information are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Signature _____ ***Today's date***: _____