

**Patient Information and Health History**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First M.I. (Preferred Name)  
 Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_ Driver License # \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_  
 E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street  
 \_\_\_\_\_  
City State Zip Code  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Approx. date of last dental visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

<input type="checkbox"/> AIDS or HIV	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Respiratory Problems	_____
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatism	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Sinus Problems	OTHER:
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stroke	<input type="checkbox"/> _____
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tumors	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> MVP-Mitral Valve Prolapse	<input type="checkbox"/> Venereal Disease	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Codeine Allergy	Do you Smoke or use
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Organ Transplant	<input type="checkbox"/> Penicillin Allergy	Tobacco?
<input type="checkbox"/> Fainting	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Currently Pregnant:	<input type="checkbox"/> MEDICATIONS	
<input type="checkbox"/> Growths	Due date: _____	Prescription or Non-Prescription	
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Radiation Treatment	(Please List)	

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems or medical conditions that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

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

**X** \_\_\_\_\_ DATE: \_\_\_\_\_  
SIGNATURE of PATIENT, PARENT or GUARDIAN

**Referral Information**

**Whom may we thank for referring you to our practice?**  Another patient, friend/family  Insurance List  Work  
 Another Dental Office  Advertisement  Other \_\_\_\_\_  
**Name of person or office referring you to our practice:** \_\_\_\_\_

**Spouse or Responsible Party Information / Insurance Information**

Name of Person(s) Primarily Responsible for Payment: \_\_\_\_\_

Relationship to Person Responsible for Payment:  Self  Spouse  Child  Other \_\_\_\_\_

Do you Have Dental Insurance?  Yes  No **If No, Skip to Below\***

Relationship to Person Insured:  Self  Spouse  Child  Other \_\_\_\_\_

If not Self, Insured's Name \_\_\_\_\_ Is insured:  Male  Female

Insured's Social Security # \_\_\_\_\_ Insured's Birth Date: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insurance Company Name & Phone # \_\_\_\_\_

Insured's Subscriber/Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

**\*IF PERSON RESPONSIBLE FOR PAYMENT OR INSURED HAS A DIFFERENT ADDRESS OR PHONE # FROM PATIENT, please complete:**

Address \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell) \_\_\_\_\_

**Consent for Services**

I authorize and give consent to the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of patient's dental needs. Upon such diagnosis, I authorize the doctor to perform all the recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. If I am a female using contraceptives, I understand antibiotics and other medications prescribed may interfere and/or reduce the effectiveness of oral contraceptives. Therefore, I understand that I will need to use an additional form of birth control, during the use of antibiotics and for one complete cycle after the antibiotics are completed. I consent to the proper disposal of any tissues or body parts that may be removed (e.g. tooth, mercury filling material, blood). I grant my permission to the doctor(s), agents, assigns to telephone me at my home or workplace to discuss matters related to this consent, my treatment, or my account. I hereby authorize Jonathan Koerperick, DDS to release any information necessary to process my family's dental claims.

**X** \_\_\_\_\_ DATE: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
**SIGNATURE of PATIENT, PARENT or GUARDIAN**

**X** \_\_\_\_\_ DATE: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
**SIGNATURE of GUARANTOR of PAYMENT/RESPONSIBLE PARTY**