

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