elements DENTAL

848 W. Coshocton Street
Johnstown, Ohio 43031
(740)966-0011
(740)966-5556
ElementsDentalOfJohnstown.com

PATIENT INFORMATION AND INSURANCE FORM

NAME: ______________________________ **Male** **Female**

ADDRESS: ______________________________

CITY: ____________________ **STATE:** __________ **ZIP:** __________

SSN: ____________________ **DOB:** ______/______/______

HOME PHONE: (______)____________ **WORK PHONE:** (______)____________ **CELL PHONE:** (______)____________

E-MAIL ADDRESS: ____________________@____________________.com

PLEASE CIRCLE ABOVE THE WAY(S) IN WHICH YOU PREFER OUR OFFICE TO CONTACT YOU.

EMPLOYER: ____________________ **OCCUPATION:** ____________________

MARITAL STATUS: **Single** **Married** **Divorced** **Widowed** **Separated** **Domestic Partner**

HOW DID YOU HEAR ABOUT ELEMENTS DENTAL: ______________________________

INSURANCE – PRIMARY

Subscriber Name: ____________________

Relationship To Patient: ____________________

Subscriber DOB: ____________________

Subscriber SSN/ID: ____________________

Subscriber Employer: ____________________

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

____

Ins. Co. Phone Number: (____)____________________

Group Number: ____________________

INSURANCE – SECONDARY

Subscriber Name: ____________________

Relationship To Patient: ____________________

Subscriber DOB: ____________________

Subscriber SSN/ID: ____________________

Subscriber Employer: ____________________

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

____

Ins. Co. Phone Number: (____)____________________

Group Number: ____________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Today's Dental all insurance benefits, if any, otherwise payable to me for services rendered.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ______________________________

Relationship: ____________________ Date: ____________________

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Parent/Guardian Signature: ____________________ Date: ____________________

Name: ____________________ elements DENTAL **Date:** ____________________

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MEDICAL HISTORY FORM

Physician's Name: ____

Physician's Phone: (_____)____________________ Date of last visit: ____________________

Are you currently under the care of a physician: YES NO

If yes, what for: ____

List any medication (including over the counter) that you are currently taking:

____

____

____

____

Do you take any of the following: (Circle) Aspirin Plavix Coumadin

Do you require anti-biotic premedication prior to dental treatment, due to heart conditions or joint replacement? YES NO

Are you currently taking any medication for osteoporosis or weak bones? YES NO

Emergency Contact:

Name: ______________________________ **Relationship:** ______________

Address: ____

City: ____________________ **State:** ______________ **Zip:** ____________

Home: ________________ **Cell:** ________________ **Work:** ______________

I understand that the information that I have given today is correct and to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: ______________________________ **Date:** ____________

Name: ______________________________ **Date:** ____________________________

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MEDICAL HISTORY AND CONDITIONS

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Allergies/To What:
____
____
Y N Anemia
Y N Angina Pectoris
Y N Arthritis
Y N Artificial Heart Valve
Y N Asthma
Y N Blood Transfusion
Y N Cancer What Kind:
____
____
Y N Radiation Therapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Facial/Jaw Surgery
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N HIV/AIDS
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis A
Y N Hepatitis B
Y N Hepatitis C
Y N High Blood Pressure
Y N Joint Replacement
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pace Maker
Y N Psychiatric Problems
Y N Radiation Therapy
Y N Rheumatic Fever
Y N Seizures
Y N Sexually Transmitted Disease
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Ulcers

IF FEMALE, PLEASE ANSWER

Y N Are you currently taking Birth Control
Y N Are you pregnant
If so, number of weeks: _________ Due Date: ______________
Y N Are you nursing

ALLERGIES

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Tetracycline

WHAT BRINGS YOU IN TODAY?

____
____

Y N Do you currently use tobacco products of any kind?

PLEASE CIRCLE:

How is your current dental health: Good Fair Poor

Are you currently in pain: YES NO

Past gum treatment or do your gums bleed now: YES NO

Do you now or have you ever had pain in the jaw: YES NO

Do you have sleep apnea: YES NO

Do you snore: YES NO

Are you under stress: YES NO

Do you like your smile: YES NO

Is there anything about your smile you would like to change:

____

Have you ever had problems with dental treatment: YES NO

When was your last dental cleaning: ______________________

When was your last dental visit: _________________________