Richard K. Test, D.D.S.

General Dentistry

Welcome!

About You ***Today's Date:*** _____

Name: _____ ☐ Male ☐ Female
Last First MI

Address: _____
City State Zip + 4

Phone: _____ Cell: _____ Occupation: _____

Employer: _____ Phone: _____

Date of Birth: ____/____/____ Age: _____ SS#: _____

Responsible Party for Payment: _____ SS#: _____

Responsible's Address: _____
City State Zip + 4

Phone: _____ Cell: _____

Spouse / Parent Name: _____ Phone: _____

Spouse / Parent Place of Work: _____ Phone: _____

Where and when are the best times to reach you? _____

In the event of an emergency, who should we contact?

Name: _____ Relation: _____

Wk #: _____ Home #: _____

How did you hear about us? _____

Insurance - ***Primary***

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insured's Name: _____ Relation: _____

Insured's Id #: _____

Insured's Address: _____
City State Zip + 4

Insured's Employer Name: _____

Group # (Plan, Local or Policy #): _____

Insured's Birthday: ____/____/____

Dental History

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment?	☐ Yes	☐ No
Are you currently in pain?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No
Do you smoke or use tobacco in any other form?	☐ Yes	☐ No

Please see reverse side

Allergies

Are you allergic to any of the following?

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

Are you allergic to any medications? _____

Medical History

Name of Physician: _____ Phone: _____

Date of Last Visit: _____

Have You ever had any of the following diseases or medical Problems?

Y N | Abnormal Bleeding	Y N | Hepatitis
Y N | Alcohol / Drug Abuse	Y N | Herpes / Fever Blisters
Y N | Anemia	Y N | High Blood Pressure
Y N | Arthritis	Y N | HIV + / AIDS
Y N | Artificial Bones / Joints / Valves	Y N | Hospitalized for Any Reason
Y N | Asthma	Y N | Kidney Problems
Y N | Blood Transfusion	Y N | Liver Disease
Y N | Cancer / Chemotherapy	Y N | Low Blood Pressure
Y N | Colitis	Y N | Mitral Valve Prolapse
Y N | Congenital Heart Defect	Y N | Pacemaker
Y N | Diabetes	Y N | Psychiatric Problems
Y N | Difficulty Breathing	Y N | Radiation Treatment
Y N | Emphysema	Y N | Rheumatic Scarlet Fever
Y N | Epilepsy	Y N | Seizures
Y N | Fainting Spells	Y N | Shingles
Y N | Frequent Headaches	Y N | Sickle Cell Disease / Traits
Y N | Galucoma	Y N | Sinus Problems
Y N | Hay Fever	Y N | Stroke
Y N | Heart Attack	Y N | Thyroid Problems
Y N | Heart Murmur	Y N | Tuberculosis (TB)
Y N | Heart Surgery	Y N | Ulcers
Y N | Hemophilia	Y N | Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

_____

Are you on any prescription / over-the counter or herbal supplement drugs? ☐ Yes ☐ No

List: _____

Have you ever taken Fosamax, or any other bisphosphanate? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

For Women:

Are you on birth control? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge.

Signature: _____ Date: _____

I understand that I am responsible for any payment of services rendered. I agree that I am responsible for all amounts not covered by insurance or which are not paid promptly by the insurance company.

Signature: _____ Date: _____