

# CURRAN & SEUBERT DENTAL OFFICE

608-742-2331

## PATIENT INFORMATION

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_  MARRIED  SINGLE  MINOR  MALE  FEMALE

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

PLACE OF EMPLOYMENT (OR SCHOOL): \_\_\_\_\_ GRADE \_\_\_\_\_ S.S.# \_\_\_\_\_

Has any member of your family ever been treated in our office?  YES  NO

How did you hear about our office? \_\_\_\_\_

## FAMILY INFORMATION

### PARENT/SPOUSE

### DENTAL INSURANCE INFORMATION

PARENT/SPOUSE				DENTAL INSURANCE INFORMATION			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME #		WORK#		HOME #		WORK#	
MO	DAY	YR	SS#	MO	DAY	YR	SS#
				EMPLOYER			
				DENTAL INSURANCE		GROUP #	

## PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

NAME \_\_\_\_\_ TEL # \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

## AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

E-mail \_\_\_\_\_

## SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_  
STATE DRIVER'S LICENSE NUMBER

X \_\_\_\_\_ DATE \_\_\_\_\_  
 Adult Patient  Father (or Husband)  Mother (or Wife)  Guardian

**FINANCE CHARGE.** If I do not pay the entire New Balance within 25 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of \$2.00 for a balance under \$134.00) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

# PLANNED CARE HEALTH RECORD

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

## DENTAL HISTORY

1. When did you last visit a dentist? \_\_\_\_\_ Were X-rays taken? \_\_\_\_\_

Did you make regular visits before then? \_\_\_\_\_

2. Are you aware of a dental problem? \_\_\_\_\_ Explain \_\_\_\_\_

3. Describe the general condition of your teeth: \_\_\_\_\_

4. If you could change the appearance of your teeth, what would you change? \_\_\_\_\_

5. Are you interested in preventing further dental problems by having regular dental examinations and care? \_\_\_\_\_

## MEDICAL HISTORY

1. Name and address of physician \_\_\_\_\_

Date of last physical (approximate) \_\_\_\_\_

2. Are you now under the care of a physician? \_\_\_\_\_ If yes, for what reason? \_\_\_\_\_

3. List all medications or drugs and dosages that you are presently taking (include non-prescription) \_\_\_\_\_

4. Are you allergic to: Penicillin \_\_\_\_\_ Codeine \_\_\_\_\_ Local Anesthetic \_\_\_\_\_ Other \_\_\_\_\_

5. (Women) Are you pregnant? \_\_\_\_\_ Due date \_\_\_\_\_

6. Circle any of the following conditions you have had (If you do not understand any of the following conditions please ask)

Heart trouble

Rheumatic fever

Ulcers

Diabetes

Thyroid problems

Tumors

Jaundice

Kidney trouble

Heart surgery

Excessive or prolonged bleeding

Heart murmur

Prosthetic Implant

Tuberculosis

AIDS/ARC/HIV

Epilepsy

Fainting Spells

Stroke

Liver trouble

High blood pressure

Asthma

Anemia

Alcohol/Chemical dependency

Glaucoma transplant

Nervous disorders

Arthritis

Hepatitis

7. Have you had any other serious illness, hospitalization, or accident? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

(Parent or guardian if a minor)