SEUBERT
Family Dentistry

WELCOME TO OUR PRACTICE
Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to ask.

PATIENT INFORMATION

Name_____ **Birthdate**_____

Address_____ **City**_____ **State** _____ **ZIP**_____

Sex ☐ **M** ☐ **F** **(Circle)** **Single** **Married** **Widowed** **Minor** **Separated** **Divorced**

E-Mail _____ **Home Phone**_____**Cell Phone**_____

How would you like to be reminded of future appointments: **E-MAIL** **HOME PHONE** **CELL PHONE** **TEXT**

Employer_____ **Employer Phone** _____

Employer Address_____ **City**_____**State**_____**ZIP**_____

Spouse OR Parent's Name_____

Spouse OR Parent's Employer_____**Work Phone**_____

Whom may we thank for referring you?_____

Person to contact in case of emergency?_____**Phone #**_____

RESPONSIBLE PARTY

Name_____Relationship to Patient_____

Address_____Phone # _____

Social Security# _____ Birthdate_____

Employer_____Work Phone_____

Currently a Patient in our office? YES NO E-mail_____

INSURANCE INFORMATION

Name of Insured_____Relationship to Patient_____

Birthdate _____ Insurance Effective Date_____

Employer _____ Work Phone _____

Employer Address_____ City_____State_____ZIP_____

Insurance Company_____Group #_____Union/Local#_____

Address_____City_____State_____ZIP_____

How much is your deductible?_____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured_____Relationship to Patient_____

Birthdate_____ Insurance Effective Date_____

Employer_____ Work Phone_____

Employer Address_____City_____State_____ZIP_____

Insurance Company_____Group #_____Union/Local#_____

Address_____City_____State_____ZIP_____

How much is your deductible?_____Max. Annual Benefit_____

DENTAL HISTORY

Reason for today's visit_____

Date of last dental visit_____ Date of last dental X-rays_____

Former Dentist_____ Address_____

If you could change the appearance of your teeth, what would you change? _____

_____

Circle if you have had a problem with any of the following:

Broken Fillings or loose teeth	**Cavities/Decay**	**Sensitivity to hot**
Bad Breath	**Gum Disease**	**Sensitivity when biting**
Bleeding Gums	**Grinding/Clenching Teeth**	**Sensitivity to sweets**
		Sensitivity to cold

How often do you Floss _____How often do you brush? _____ Do you use an Electric Toothbrush? Y N

MEDICAL HISTORY

Physician's Name:_____ Phone Number:_____

Address:_____ Date of last visit_____

Circle to indicate if you have any of the following conditions that may require premedication for dental treatment:

Joint replacement(s) Mitral valve prolapse Artificial heart valve Infective endocarditis

Have you ever used a bisphosphonate medication? Common brands- Fosamax, Actonel, Atelvia, Didronel, Boniva Y N

Do you currently or have you ever used tobacco products? Form:_____

Have you had any serious illnesses, communicable diseases, operations, or hospitalizations? Y N

If yes, describe_____

_____

Please circle to indicate if you have had any of the following:

Anemia	**Chemical Dependency**	**High Blood Pressure**	**Shortness of Breath**
Arthritis, Rheumatism	**Chemotherapy**	**Hepatitis**	**History of Stroke**
Artificial Heart Valve	**Cough, Persistent**	**HIV/ARC/AIDS**	**Swelling of Feet or Ankles**
Artificial Joints/Implants	**Diabetes: Current A1c: _____**	**Kidney Disease**	**Thyroid Disease**
Asthma	**Epilepsy**	**Mitral Valve Prolapse**	**Tuberculosis**
Back Problems	**Fainting**	**Pacemaker**	**Tumors**
Bleeding Abnormality	**Glaucoma Transplant**	**Radiation Treatment**	**Ulcers**
Blood Disease	**Heart Murmur**	**Respiratory Disease**	**Venereal Disease/STI**
Cancer	**Heart Disease/Surgery**	**Rheumatic Fever**	

List Medications you are currently taking and why:

_____

_____

_____

_____

_____

ALLERGIES?

Penicillin _____ Codeine_____ Local Anesthetic_____

OTHER:_____

_____

Are you currently taking blood thinning medication? Y N

If yes, describe_____

(WOMEN) Are you pregnant? Y N Nursing? Y N Taking Birth Control Pills? Y N

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in medical or oral health. I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to **SEUBERT FAMILY DENTISTRY, LLC** 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 authorize the use of my signature on all insurance submissions. The above named dentist/dental office may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent is effective today until the date I provide written withdrawal of consent.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

Payment is due in full at time of dental treatment unless prior arrangements have been approved.