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? _______________________________
(Home Phone, Cell Phone, E-mail, or Text)

Employer_______________________________ **Employer Phone** _______________________________

Employer Address_______________________________ **City**______________**State**________**ZIP**______________

Spouse OR Parent's Name_______________________________

Spouse OR Parent's Employer_______________________________**Work Phone**______________

School/College (if student) _______________________________

Whom may we thank for referring you?_______________________________

Person to contact in case of emergency?_______________________________**Phone #**______________

RESPONSIBLE PARTY

Name of Person
Responsible for this Account_______________________________Relationship to Patient______________

Address_______________________________Phone # _______________________________

Driver's License #_______________________________Birthdate______________Bank______________

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?____

____

Are you interested in preventing further dental problems by having regular dental examinations and care?_________________

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

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

How often do you Floss? ____________How often do you Brush?__________Do you use a Electric Toothbrush?_____________

MEDICAL HISTORY

Physician's Name____ Phone Number ____

Address____Date of last visit____

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

Have you had any serious illnesses or operations? Y N If yes, describe____

____

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

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

Anemia	**Chemical Dependency**	**Hepatitis**	**Shortness of Breath**
Arthritis ,Rheumatism	**Chemotherapy**	**High Blood Pressure**	**Stroke**
Artificial Heart Valve	**Cough, Persistent**	**HIV/ARC/AIDS**	**Swelling of feet or ankles**
Artificial Joints/Implants	**Diabetes**	**Kidney Disease**	**Thyroid Problems**
Asthma	**Epilepsy**	**Mitral Valve Prolapse**	**Tobacco/Cigarette Habit**
Back Problems	**Fainting**	**Pacemaker**	**Tuberculosis**
Bleeding Abnormally	**Glaucoma Transplant**	**Radiation Treatment**	**Tumors**
Blood Disease	**Heart Murmur**	**Respiratory Disease**	**Ulcer**
Cancer	**Heart Disease/Surgery**	**Rheumatic Fever**	**Venereal Disease**

____

List Medications you are currently taking and why:

____

____

____

____

ALLERGIES to medications?

Penicillin _______ Codeine______ Local Anesthetic________

OTHER:____

____

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

(Insurance Company)

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.