PATIENT INFORMATION

Patient's Name _____
Last First Middle

Address _____ Apt. # _____

Address _____ _____ _____
City State Zip

Phone#'s
Home _____ Cell _____ Work _____

Email Address _____ Male ___ Female ___ Age _____

Date of Birth _____ Soc. Sec. # _____

___ Married ___ Widowed ___ Single ___ Child ___ Separated ___ Divorced Full-Time Student: YES ____ NO ____

Occupation_____ Employer/School Name _____

Who is responsible for account? _____ Relationship to Patient _____

Who should we thank for referring you? _____

DENTAL INSURANCE

Primary Insurance _____ Subscriber _____

Subscriber ID# _____ Group # _____ DOB _____

Secondary Insurance _____ Subscriber _____

Subscriber ID# _____ Group # _____ DOB _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s), have insurance coverage with _____
And assign directly to Klein, Begnoche, and Tumminia Dental, P.A. all insurance benefits, if payable by insurance. I authorize the use of my signature on all insurance submissions. Klein, Begnoche, & Tumminia Dental, P.A. 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 payment for services and determining insurance benefits payable for related services.

_____ _____
Signature of Patient, Parent, or Guardian Date

Relationship to Patient _____

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Cell Phone_____

Todays Date _____

DENTAL HISTORY

Please check (√) all that apply

____ Chew on one side of mouth
____ Fingernail biting
____ Gums swollen or tender
____ Loose teeth or broken filings
____ Pain around the ear
____ Sensitivity to cold
____ Sores or growths in your mouth
____ Clicking or popping Jaw
____ Food Collection between the teeth
____ Jaw Pain
____ Mouth breathing
____ Periodontal treatment
____ Sensitivity to sweets
____ Oral Surgery
____ Dry Mouth
____ Grinding Teeth
____ Lip or cheek biting
____ Orthodontic treatment
____ Sensitivity to heat
____ Sensitivity when biting

How often do you floss?_____ How often do you brush?_____ Date of last x-rays_____

Do you pre-medicate with antibiotics before dental treatment? _____ If yes which antibiotic? _____

Have you ever had any orthopedic surgery or artificial joint replacement? _____ When? _____

MEDICAL HISTORY

1. Are you having any dental problems at this time?..... ☐ YES ☐ NO
2. Do your gums bleed at any time? ..... ☐ YES ☐ NO
3. Do you feel very nervous about having dental treatment..... ☐ YES ☐ NO
4. Have you ever had a bad experience in a dental office?..... ☐ YES ☐ NO
5. Have you been a patient in the hospital during the past two years?..... ☐ YES ☐ NO
   If yes, for what reason? _____
6. Have you been under the care of a medical doctor during the past two years?..... ☐ Yes ☐ NO
   If yes, for what reason? _____
7. Have you taken any medicine or drugs the past two years?..... ☐ YES ☐ NO
8. Have you ever had any excessive bleeding requiring special treatment?..... ☐ YES ☐ NO
9. Check any of the following that you have had or have at present:

☐ AIDS/HIV
☐ Anemia
☐ Angina Pectoris (chest pain)
☐ Allergies or Hives
☐ Artificial Heart Valves
☐ Arthritis, Rheumatism
☐ Asthma
☐ Back Problems
☐ Bleed abnormally
☐ Blood Disease
☐ Bruise Easily
☐ Blood Transfusion
☐ Cancer
☐ Circulatory Problems
☐ Cold Sores or Fever Blister
☐ Congenital Heart Lesions
☐ Cough, persistent or bloody
☐ Cosmetic Surgery
☐ Cortisone Medication
☐ Diabetes
☐ Drug Addiction/Alcoholism
☐ Emphysema
☐ Epilepsy or Seizures
☐ Hay Fever
☐ Headaches
☐ Heart Surgery
☐ Heart Problems
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis Type____
☐ Herpes
☐ High Blood Pressure
☐ Jaundice
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervousness
☐ Pacemaker
☐ Pain in Jaw Joints
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sickle Cell Disease
☐ Shortness Of Breath
☐ Sinus Trouble
☐ Skin Rash
☐ Special Diet
☐ Stroke
☐ Swollen Feet or Ankles
☐ Swollen Neck Glands
☐ Thyroid Problems
☐ Tobacco use
☐ Tonsillitis
☐ Tumor or Growth on head or neck
☐ Ulcers
☐ Venereal Disease
☐ Weight Loss, Unexplained
☐ X-Ray or Cobalt treatment

Are you taking or have you ever taken any medication for osteoporeosis? Such as Fosamax, Boniva, Aredia, Zometa, Actonel. _____

Women: Are you Pregnant? ☐ YES ☐ NO Due Date_____ Are you nursing? ☐ YES ☐ NO
Are you taking birth controls pills? ☐ YES ☐ NO Do you use more than two pillows to sleep? ☐ YES ☐ NO

List any medications you are currently taking and the correlating diagnosis:_____

_____

ALLERGIES: ☐ Aspirin ☐ Latex ☐ Codeine ☐ Penicillin ☐ Iodine ☐ Sulfa ☐ Barbiturates

☐ Other_____

Pharmacy Name _____ Phone_____

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PATIENT RESPONSIBITY

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor. It is not a substitute for payment. It is understood that your insurance is filed as a courtesy, and your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The patient/guarantor is responsible for the entire balance in the event that the insurance company denies payment for any reason. You will be responsible for all collection costs. Please remember that insurance is not a guarantee of payment for any reason. All claims filed are subject to review.

To all new and existing patients, your appointment must be cancelled at least 24 hours before the appointment to avoid a cancellation fee of $75.00.

Name _____

Signature _____

Date _____

PRIVACY PRACTICE ACKNOWLEDGMENT

I have been made aware of this office's Notice of Privacy Practices and have been provided an opportunity to review it. I am aware that a copy will be provided to me upon my request.

Name _____

Signature _____

Date _____