Patient Information

Name _____

SS/HIC/Patient ID #_____

Date_____

Address_____

City_____

State _____ Zip_____

E-mail_____

Sex □ M □ F Age _____

Birth date _____

□ Married □ Widowed □ Single □Minor
□ Separated □ Divorced □ Partnered for_____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____)_____

Spouse's Name _____

Birthdate_____

SS#_____

Spouse's Employer_____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account _____

Relationship to Patient _____

Insurance Co. _____

Group #_____
Is patient covered by additional insurance? □Yes □No

Subscriber's Name _____

Birthdate _____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
Name of company(ies)

Dr._____ 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 doctor may use 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 or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature

_____
Please print name

_____ _____
Date Relationship to Patient

Phone Numbers

Home (____)_____ Work (____)_____ Ext_____Cell Phone (____)_____

Spouse's Work (____)_____ Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship _____

Home (____)_____ Work (____) _____

Dental Health History:

Correct answers to the following questions will allow Dr. Gecovich to treat you on a more individual basis, providing the care appropriate for your particular needs. Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
Do you like your smile? If not why? _____	□	□
Last known x-rays taken? _____		
Last visit to the Dentist? _____		
Gum Pain/Bleeding.....	□	□
Do you have a history of Gum Disease?.....	□	□
Jaw Pain ?.....	□	□
Do you smoke?.....	□	□
Do you have pain when you bite?.....	□	□
Have you ever had a joint replaced?.....	□	□
How often do you floss? _____		
How often do you brush?_____		

Health History:

Correct answers to the following questions will allow Dr. Gecovich to treat you on a more individual basis, providing the care appropriate for your particular needs. Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
Are you in good health now?	☐	☐
Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____	☐	☐
Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain _____	☐	☐
Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
(Women) Are you pregnant? If so, give due date _____	☐	☐
(Women) Are you on birth control medication? _____	☐	☐
Do you use tobacco in any form? If yes, how much _____	☐	☐

Do you have any of the following?

GENERAL

	YES	NO
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐

SKIN

Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐

EYES

Visual change	☐	☐
Glaucoma	☐	☐

EARS

Loss of hearing	☐	☐
Ringing in ears	☐	☐

NOSE

Frequent nosebleeds	☐	☐
Sinus problem	☐	☐

THROAT

Soreness/hoarseness	☐	☐

NERVOUS SYSTEM

Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐

RESPIRATORY

Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐

ENDOCRINE

Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐

Other_____

HEART/BLOOD VESSELS

	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐

Other_____

BONE/MUSCLES

Arthritis/rheumatism	☐	☐
Artificial joints	☐	☐

DIGESTIVE SYSTEM

Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
GERD	☐	☐

URINARY

Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐

BLOOD

Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐

OTHER

Radiation therapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐

ALLERGIES

Are you allergic or have you ever experienced any reaction to the following?

	YES	NO
Local anesthetics	☐	☐
Barbiturates (sleeping pills)	☐	☐
Penicillin (antibiotics)	☐	☐
Latex	☐	☐
Sulfa	☐	☐
Codeine	☐	☐
Iodine	☐	☐

Other_____

MEDICATIONS

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

_____

_____

_____

_____

_____

Pharmacy Name_____

Phone (____)_____

Physician's Name_____

Physician's Phone (_____)_____

To the best of my knowledge, all of the preceding answers are true and correct

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment

_____ _____

Signature Date