# Dewitt Dentistry Patient Information (Confidential)

Patient Name_____ Date of Birth_____ Social Security #_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ E-Mail_____

Minor___ Single___ Married___ Divorced___ Widowed___ Separated___ Employer_____

Work Phone_____ Employer Address_____

Spouse/Parent Name_____ Spouse/Parent Employer_____

Spouse/Parent Work Phone_____ Permission to relay confidential info to:_____

**Emergency Contact_____ Relationship:_____ Phone #_____

How did you hear about our office/Who referred you?_____

## PRIMARY DENTAL INSURANCE

Employee Name_____ D.O.B._____

Employer Name_____

SS# of Insured_____

Name of Insurance Company_____

Address of Ins. Co._____

Phone_____ Policy #_____

## SECONDARY DENTAL INSURANCE

Employee Name_____ D/O/B_____

Employer Name_____

SS# of Insured_____

Name of Insurance Company_____

Address of Ins. Co._____

Phone_____ Policy#_____

## PATIENT MEDICAL HISTORY

Primary Care Physician: _____ Phone:_____ Address_____

Last Exam_____ Are you currently being treated? _____ What is being treated? _____

Have you ever been hospitalized for any surgery or illness? YES NO If **yes** what was the problem_____

_____

**List any medications you are currently taking (prescription OR OTC)** _____

_____

Are you in good health? YES NO Have there been any changes in your health in the past year? YES NO

If yes, what has changed? _____

**Do you have any of the following conditions?**

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure | YES | NO | Heart Disease | YES | NO |
| Stroke | YES | NO | Cardiac defibrillator/Pace Maker | YES | NO |
| Chest Pains | YES | NO | Heart Murmur | YES | NO |
| Heart Attack | YES | NO | Valve replacement therapy | YES | NO |
| Rheumatic fever | YES | NO | Mitral Valve prolapse | YES | NO |
| Anemia | YES | NO | Are you on aspirin therapy | YES | NO |
| Are you on blood thinners | YES | NO | Frequently Tired | YES | NO |
| Swollen Ankles | YES | NO | Fainting/Dizziness | YES | NO |
| Easily Winded | YES | NO | Asthma | YES | NO |
| Migraine Headaches | YES | NO | Epilepsy/seizures | YES | NO |
| Arthritis | YES | NO | Allergy to latex products | YES | NO |
| Hay fever/Allergies | YES | NO | | | |
| Allergies to medications | YES | NO | If yes please list_____ | | |

OVER →

| | | | | | |
|---|---|---|---|---|---|
| Emphysema | YES | NO | Tuberculosis | YES | NO |
| Chronic Bronchitis | YES | NO | Thyroid Problems | YES | NO |
| Diabetes | YES | NO | Glaucoma | YES | NO |
| Joint replacement/implant | YES | NO | Organ Transplant | YES | NO |
| Leukemia | YES | NO | Cancer | YES | NO |
| Radiation Therapy | YES | NO | Chemotherapy | YES | NO |
| Hepatitis/Jaundice/Liver disease | YES | NO | Colon Disease | YES | NO |
| Mononucleosis | YES | NO | Diverticular disease | YES | NO |
| Peptic Ulcer | YES | NO | Reflux esophagitis | YES | NO |
| Kidney Disease | YES | NO | Sexually transmitted disease | YES | NO |
| Prostate Disease | YES | NO | AIDS or HIV Infection | YES | NO |
| Are you wearing contact lenses? | YES | NO | Do you have hearing difficulties? | YES | NO |

Do you smoke? YES NO How much? _____ Frequency of Alcohol consumption_____

## DENTAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| Do your gums bleed while brushing? | YES | NO | Are your teeth sensitive to hot/cold? | YES | NO |
| Are your teeth sensitive to sweet/sour? | YES | NO | Do you have any sores in or near your mouth? | YES | NO |
| Have you had any neck or jaw injuries? | YES | NO | Do you clench or grind your teeth? | YES | NO |
| Do you have frequent headaches? | YES | NO | Have you ever had a difficult extraction? | YES | NO |
| Do you bite your lips/cheeks frequently? | YES | NO | Have you ever had orthodontic work? | YES | NO |
| Ever experienced clicking in your jaw? | YES | NO | Ever had difficulty in opening/closing mouth? | YES | NO |
| Ever experience pain (joint,ear,side of face)? | YES | NO | Difficulty Chewing? | YES | NO |

| | | |
|---|---|---|
| Are you wearing removable dental appliances? | YES | NO |
| Have you ever had instructions on how to care for your teeth? | YES | NO |
| Have you ever had instructions on how to care for your gums? | YES | NO |

What is your chief dental complaint? _____

## WOMEN ONLY

Are you pregnant, think you may be? YES NO If yes, when is your due date? _____

| | | | | | |
|---|---|---|---|---|---|
| Are you nursing? | YES | NO | Estrogen Replacement Therapy | YES | NO |
| Are you taking Birth Control Pills? | YES | NO | Medication for Osteoporosis? | YES | NO |

## Authorization and Release

### Consent to examination and treatment

I herby give my consent for the above named patient to receive dental examinations and diagnostic procedures with Wm. E. DeWitt D.D.S., P.C. Such examination and treatment may include, but shall not be limited to, all necessary procedure including the use of anesthesia deemed advisable by the dental staff in the exercise of their professional judgment.

### Assignment of insurance benefits & guaranty of payment

In consideration of the professional care provided to the above named patient, I herby assign, transfer and set over to any dental reimbursement under my insurance policy or health benefit indemnification agreement payable to me for services rendered by Wm. E. DeWitt D.D.S., P.C.

I understand that I will be fully responsible for payment of any and all charges not covered by insurance at the current rates established by Wm. E. DeWitt D.D.S.; P.C. for all services rendered the above patient from date hereof and thereafter. I further understand that I shall be responsible for any expense of Wm. E. DeWitt D.D.S., P.C. in collecting the amounts guaranteed herby, including all costs of collection, reasonable attorney's fees and costs and all other collection expenses. Finance charges at 1-1 ½% per month (18% annum) shall be applied to accounts with open balances after 30 days of service rendered. I understand that if I fail to make it to an appointment and do not give at least 24 hours notice I will be responsible to pay a missed appointment fee.

****YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR EMPLOYER. IT IS IMPOSSIBLE FOR US TO KNOW EVERY PATIENT'S' POLICY AS ALL OF THEM DIFFER. ANY CLAIM NOT COVERED FOR ANY REASON IS YOUR RESPONSIBILITY. (ie: Missing tooth clause, waiting periods, non covered procedures, implants, etc.) IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE COMPANY AND SEE WHAT YOUR POLICY PROVISIONS ENTAIL.**

### Authorization for disclosure of information

I herby authorize Wm. E. DeWitt D.D.S., P.C. to release all medical and dental information that may be necessary for the payment on my behalf of the health care services rendered to the above named patient.

Signature_____ Date_____