We are complimented that you have selected us to provide dental care for you and your family.
So that we can serve you better, please complete both sides of the patient history form.

Patient Information

Patient's Name ____
Last First Middle How do you wish to be addressed?

Address ______________________________ City ________________ State________ Zip __________
Home Phone ( )________________ Work ( )________________ Ex____ Cell ( )________________
Best # to use? H W C Birth Date ____________________ Male _______ Female_______
Email Address ____
If patient is a minor, give parent's or guardian's name ____
Employer ____ Occupation __________________________
Spouse's Name __________________________________ Birth Date ___________________________
Spouse's Employer__________________ Occupation ________________ Work Phone _____________
Whom may we thank for referring you to our office? ____

Responsible Party / Billing Information

(If different from above)

Name ____
Address ______________________________ City ________________ State ________ Zip _________
Home Phone ( ) ________________ Work ( )________________ Ex____ Cell ( )________________
Birth Date ______________ Relationship to patient ________________________

Dental Insurance Information

Insured's Name _____________________________ Birth Date ______________ SSN/ID ____________
Insurance Co. ____ Group # _____________________
Insurance Co. Address (billing) ____
Ins. Co. Phone ________________ Insured's Employer ______________________________________
Do you have dual coverage? Yes No If yes:
#2 Insured's Name ________________________ Birth Date ____________ SSN/ID _____________
Insurance Co. ____________________________________Group # ________________________
Insurance Co. Address ____
Ins. Co. Phone _____________ Insured's Employer _____________________________________

Emergency Contact

Name of nearest relative not living with you ______________________________ Relationship _____________
Address _____________________________________ City ____________________ State ______ Zip __________
Phone # H ___________________ W ___________________ Cell ___________________ Best way to contact? H W C

Consent for Treatment

I hereby authorize Dr. Deborah A. Struckmeier to administer any treatment such as x-rays, anesthetics and to perform any dental procedures deemed necessary or advisable in the diagnosis and treatment of my dental condition. I authorize release of any information relating to this claim. I realized that I am ultimately responsible for all cost of treatment. I understand the use of anesthetic agents embodies a certain risk. I hereby authorize my insurance benefits to be paid directly to Dr. Deborah A. Struckmeier.

Date __________________ Signature (patient or parent if minor) ____

After initial X-rays and examination we will give you and estimate of fees to cover your treatment. At that time financial arrangements will be made before treatment is rendered.

Medical History

Physician's Name ____ Phone ___________________
Surgeon Name ____ Phone ___________________
How would you describe your health? ____
Have you been hospitalized or under a physicians care in the last 2 years? ___________________________
If YES, Why? ____
Please list ***all*** prescribed and/or over-the-counter ***medications*** you are taking:
____
____
____
Pharmacy ____ Phone __________________

Have you ever had an adverse reaction to any medications or substances? (Please circle all that apply.)

Aspirin	Valium	Sulfa Drugs	Penicillin	Novocaine	Nitrous Oxide
Latex	Codeine	Iodine	Tetracycline	Xylocaine	Erythromycin

Other ____

Have you ever had any of the following? (Please circle all that apply.)

Heart Trouble	Dizziness or Fainting	Hepatitis Type:	HIV-AIDS-ARC
High Blood Pressure	Diabetes	Cancer	Venereal Disease
Low Blood Pressure	Kidney or Liver Disease	Tumor or Growth	Cold Sores
Heart Attack	Ulcers or G.I. Problems	Chemo Therapy	Fever Blisters
Stroke	Thyroid Problems	Arthritis or Gout	Herpes
Heart Murmur	Asthma or Allergies	Jaw Joint Pain	Bruise Easily
Rheumatic Fever	Sinus Problems	Glaucoma	Frequent Thirst
Congenital Heart Problems	Emphysema	Epilepsy or Seizures	Frequent Urination
Heart Valve or Pacemaker	Lung Disease	Hypoglycemia	Use Tobacco
Bleeding Problems or Anemia	Tuberculosis	Drug/Alcohol Addiction	Now Pregnant
Blood Disease	Psychiatric Care	Eating Disorder	Surgery
Blood Transfusion	High Cholesterol	Artificial Joint	

Are there any surgically placed foreign object(s) in your body (i.e. pins, screws, plates, webbing, meshing, etc.)? ____
____

Office Use Only

Update / /	Update / /	Update / /	Update / /
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________
Patient Initials _______	Patient Initials _______	Patient Initials _______	Patient Initials _____

Update / /	Update / /	Update / /	Update /
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Patient Initials _______	Patient Initials _______	Patient Initials _______	Patient Initials _____