Patient Information

Round Hill Dental

Patient's Name:_____ ☐M ☐F Today's Date____/____/____
Last First

Contact Number: _____ Work: _____

Date of Birth: _____ Social Security Number: _____

Address: _____
Street APT# City State Zip Code

Person to contact in case of an emergency: _____ Relationship _____ Phone #_____

Primary Insurance Information

Subscriber's Name: _____
Relationship w/ Patient: _____
Is the subscriber a patient: ☐YES ☐NO
Social Security #: _____
Date of Birth: _____
Employer: _____
Address: _____
Phone #: _____

Name of Insurance Company: _____
Phone #: _____
Union/Group #: _____

Secondary Insurance Information

Subscriber's Name: _____
Relationship w/ Patient: _____
Is the subscriber a patient: ☐YES ☐NO
Social Security #: _____
Date of Birth: _____
Employer: _____
Address: _____
Phone #: _____

Name of Insurance Company: _____
Phone #: _____
Union/Group #: _____

Responsible Party

Name of the person responsible :_____ Relationship w/ patient_____

Date of Birth _____ Social Security Number _____ Driver License _____

Address _____
Street APT# City State Zip Code

Date of last dental visit: ____/____/_____

Reason for dental visit:

Dental History

Do you have dental examinations on a routine basis? ☐YES ☐NO
Do you think you have cavities or gum disease? ☐YES ☐NO
Do you brush and floss daily? ☐YES ☐NO
Are you dissatisfied with your teeth appearance? ☐YES ☐NO
Does you gum ever bleed? ☐YES ☐NO
I think my dental health is: ☐EXCELLENT ☐GOOD ☐BAD ☐POOR
Are your teeth sensitive to sweets, hot, cold, or to biting pressure? ☐YES ☐NO

Name of your previous dentist? _____ Location (city)_____

AUTHORIZATION & RELEASE

I have read and answered the above question to the best of my knowledge. I authorize and request my insurance company to pay directly to Round Hill Dental otherwise payable to me. I authorize this office to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Signature of patient / parent / guardian Print Date

Health History

Patient's Name:_____ ☐ Child ☐M ☐F Today's Date__/___/_____
Last First

Please answer each question by checking the appropriate box

1. Are you in good health? ☐ YES ☐ NO

2. Date of last physical examination ___/___/_____

3. Are you now under a care of a physician? ☐ YES ☐ NO
If yes, what is the condition being treated? _____

Doctor's Name_____ Phone Number _____ Location (city)_____

4. Have you ever had any serious illness or operation or been hospitalized? ☐ YES ☐ NO
If yes, please explain _____

5. Are you taking any medications?
If yes, please list:

6. Are you using any recreational drugs (marijuana, cocaine) or controlled substances? ☐ YES ☐ NO

7. Have you been pre-medicated with antibiotics for your dental treatment? ☐ YES ☐ NO
8. Are u sensitive or allergic to: ☐ Penicillin. ☐ Tetracycline ☐ Erythromycin ☐ Aspirin ☐ Codeine ☐ Latex

Other_____

Do you have or have you had any of the following:

☐ YES ☐ NO AIDS/HIV
☐ YES ☐ NO Allergies or hives
☐ YES ☐ NO Allergies to metals
☐ YES ☐ NO Anemia
☐ YES ☐ NO Angina pectoris
☐ YES ☐ NO Arthritis
☐ YES ☐ NO Artificial heart valve
☐ YES ☐ NO Asthma
☐ YES ☐ NO Blood disease
☐ YES ☐ NO Blood transfusion
☐ YES ☐ NO Bruise easily
☐ YES ☐ NO Cancer
☐ YES ☐ NO Chemotherapy
☐ YES ☐ NO Cold sores
☐ YES ☐ NO Congenerical heart lesions
☐ YES ☐ NO Cortisone medicine
☐ YES ☐ NO Diabetes
☐ YES ☐ NO Dizziness
☐ YES ☐ NO Difficulty in swallowing
☐ YES ☐ NO Drug addiction
☐ YES ☐ NO Emphysema
☐ YES ☐ NO Epilepsy
☐ YES ☐ NO Excessive bleeding
☐ YES ☐ NO Fainting spells or seizure
☐ YES ☐ NO Glaucoma
☐ YES ☐ NO Growths
☐ YES ☐ NO Hay fever
☐ YES ☐ NO Head injuries
☐ YES ☐ NO Heart attack
☐ YES ☐ NO Heart failure
☐ YES ☐ NO Heart murmur
☐ YES ☐ NO Hemophilia
☐ YES ☐ NO Hepatitis
☐ YES ☐ NO Herpes
☐ YES ☐ NO High blood pressure
☐ YES ☐ NO Jaundice
☐ YES ☐ NO Joint replacement
☐ YES ☐ NO Kidney disease
☐ YES ☐ NO Liver disease
☐ YES ☐ NO Mental disorder
☐ YES ☐ NO Mitral valve prolapse
☐ YES ☐ NO Nervous disorder
☐ YES ☐ NO Pain in jaw joints
☐ YES ☐ NO Pacemaker
☐ YES ☐ NO Psychiatric treatment
☐ YES ☐ NO Radiation treatment
☐ YES ☐ NO Respiratory disease
☐ YES ☐ NO Rheumatic fever
☐ YES ☐ NO Rheumatism
☐ YES ☐ NO Sickle cell
☐ YES ☐ NO Sinus trouble
☐ YES ☐ NO Stomach ulcer
☐ YES ☐ NO Stroke
☐ YES ☐ NO TMJ
☐ YES ☐ NO Thyroid disease
☐ YES ☐ NO Tonsilitis
☐ YES ☐ NO Tuberculosis
☐ YES ☐ NO Tumors
☐ YES ☐ NO Ulcers
☐ YES ☐ NO Venereal disease

_____
Dentist Signature Date

Do you smoke? ☐YES ☐ NO
Do you consume alcoholic beverages? ☐ YES ☐ NO
Have you ever taken the drug "Fen-Phen" or 'Redux" ☐ YES ☐ NO
Have you taken the drug Biphosphate? ☐ YES ☐ NO
Are you pregnant? If yes, how many weeks/months ☐ YES ☐ NO
Do you have any problems associated with your menstrual period? ☐ YES ☐ NO
Do you take birth control pills? ☐ YES ☐ NO
Is there anything we should know about your health that is not mentioned above? ☐ YES ☐ NO
Please explain_____

_____ _____ _____
Signature of patient / parent / guardian Print Date

_____ _____
Dentist Signature Date