# RANDOL MILL FAMILY DENTISTRY

*Dentistry With a Magic Touch*

## PATIENT INFORMATION

| | | |
|---|---|---|
| Name | Birthdate | Home Phone ( ) |
| Address | City | State Zip: |

Sex ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐Partnered for years

| | | |
|---|---|---|
| E-mail | Cell Phone #1 ( ) | Cell Phone #2 ( ) |
| Employer/School | Employer/School Phone ( ) | |
| Employer/School Address | City | State Zip |
| Spouse or Parent's Name | Employer | Work Phone ( ) |
| Whom may we thank for referring you? | | |
| Person to contact in case of emergency | | Home Phone ( ) |

## RESPONSIBLE PARTY

| | | |
|---|---|---|
| Name of person<br>Responsible for this account: | | Relationship<br>to Patient |
| Address: | | Home Phone ( ) |
| Driver's License # | Birthdate | Bank |
| Currently a patient in our office? ☐Yes ☐No | Email | Cell Phone ( ) |

## INSURANCE INFORMATION

| | | |
|---|---|---|
| Name<br>of Insured | | Relationship<br>to Patient |
| Birthdate | Social Security # | Date Employed |
| Employer | | Work Phone ( ) |
| Employer Address | City | State Zip |
| Insurance Company | Group # | Union o Local # |
| Address | City | State Zip |
| How much is your deductible? | How much<br>have you used? | Max Annual<br>Benefit |

## ADDITIONAL INSURANCE

| | | |
|---|---|---|
| Name of Insured | | Relationship to Patient |
| Birthdate | Social Security # | Date Employed |
| Employer | | Work Phone ( ) |
| Employer Address | City | State Zip |
| Insurance Company | Group # | Union o Local # |
| Address | City | State Zip |
| How much is your deductible? | How much<br>have you used? | Max Annual<br>Benefit |

------over-----

## DENTAL HISTORY

| Reason for today's visit | Date of last dental care |
|---|---|
| Former Dentist | Date of Last Dental X-Rays |
| Address | |

Check ( ✓ )if you have had problems with any of the following:

| | | | |
|---|---|---|---|
| ☐ Bad Breath | ☐ Grinding teeth | ☐ Sensitivity to hot | ☐ Bleeding Gums |
| ☐ Sensitivity to Sweets | ☐ Clicking or popping jaw | ☐ Sensitivity to hot | ☐ Periodontal treatment |
| ☐ Sensitivity when biting | ☐ Loose teeth or broken fillings | ☐ Sensitivity to cold | ☐ Sores or growths in your mouth |
| ☐ Food Collection between teeth | How often do you floss? | How often do you brush? | |

## MEDICAL HISTORY

| Physician's Name | Date of Last Visit |
|---|---|

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of lonimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (desfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes describe ____________________________________________________

Have you had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ________________________________________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control pills? ☐ Yes ☐ No

Check ( ✓ )if you have had problems with any of the following:

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Congenital Heart Lesions | ☐ Hepatitis | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cortisone Treatments | ☐ Hernia Repair | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Skin Rash |
| ☐ Artificial Joints. Pins, etc. | ☐ Cough up blood | ☐ HIV/AIDS | ☐ Stroke |
| ☐ Asthma | ☐ Diabetes | ☐ Jaw Pain | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Epilepsy | ☐ Kidney Disease | ☐ Thyroid Problems |
| ☐ Bleeding Abnormally | ☐ Fainting | ☐ Liver Disease | ☐ Tobacco Habit |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tonsillitis |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Ulcer |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Venereal Disease |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | |

| List of medications you are currently taking and the correlating diagnosis: | Allergies: |
|---|---|
| | |
| | |
| | |

## AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
I certify that I, and/or my dependent(s), have insurance coverage with ____________________________and assign directly to 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 dentist 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 or the benefits payable for related services.

_______________________________________________ _______________________
Signature of Patient. Parent, Guardian or Personal Representative — Date

_______________________________________________ _______________________
Please print name of the patient, Parent, Guardian or Personal Representative — Relationship to the patient

**PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**