O'FALLON
DENTALWORKS
FAMILY DENTISTRY

2726 HWY K
O'FALLON, MISSOURI 63368
636-272-5015
OFALLONDENTALWORKS.COM

## PATIENT INFORMATION

Date _____ Name _____
Last Name First Name MI Preferred Name

Home Phone (___) _____ Cell Phone (___) _____ SSN# _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ❑ M ❑ F Age_____ Birthdate _____ ❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered for years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (___) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (___) _____

## PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate_____ Soc. Sec.#_____

Address (If different from patient's) _____ Phone (___)_____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Insurance Company _____

Contract# _____ Group# _____ Subscriber # _____

## ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient 's)_____ Phone (___)_____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (___)_____

Insurance Company _____ SSN# _____

Contract# _____ Group# _____ Subscriber # _____

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage _____ with and assign directly to
Name of Insurance 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 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient Parent Guardian or Personal Representative Relationship to Patient

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## 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
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to cold
❑ Sensitivity to hot
❑ Sensitivity to sweets
❑ Sensitivity when biting
❑ Sores or growths in your mouth

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 Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, describe _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate date _____

(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
❑ Arthritis, Rheumatism
❑ Artificial Joints
❑ Artificial Heart Valves
❑ Asthma
❑ Autism
❑ Back Problems
❑ Blood Disease
❑ Cancer ❑ Active ❑ Remission
❑ Chemical Dependency
❑ Chemotherapy
❑ Circulatory Problems
❑ Cortisone Treatments
❑ Cough, Persistent
❑ Diabetes
❑ Epilepsy
❑ Fainting
❑ Glaucoma
❑ Headaches
❑ Heart Murmur
❑ Heart Problems
❑ Hemophilia
❑ Hepatitis
❑ High Blood Pressure
❑ HIV/AIDS
❑ Jaw Pain
❑ Kidney Disease
❑ Liver Disease
❑ Mitral Valve Prolapse
❑ Pacemaker
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Shortness of Breath
❑ Skin Rash
❑ Stroke
❑ Swelling of Feet or Ankles
❑ Thyroid Problems
❑ Tobacco Habit
❑ Tonsillitis
❑ Tuberculosis
❑ Ulcer
❑ Venereal Disease
❑ Other _____

## MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone (____)_____

## ALLERGIES

❑ Aspirin
❑ Barbiturates (Sleeping pills)
❑ Codeine
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Latex _____
❑ Other _____
_____

## SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature_____