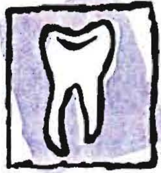

Dr. Angela Gasser, D.D.S.

Family Dentistry

Patient Information

Date __________ SS# __________

Patient __________

Address __________

____

Sex: ☐ M ☐ F Age ____ Birth Date __________

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Occupation __________

Employer __________

Emp. Address __________

Emp. Phone __________

Spouse's Information

Name __________

Birthdate __________ SS# __________

Occupation __________

Employer __________

Whom may we thank for referring you? __________

____

Dental Insurance Information

Who is responsible for this account? __________

Relationship to Patient __________

Insurance Co. __________

Group # __________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name __________

Birthdate __________ SS# __________

Relationship to Patient __________

Insurance Co. __________

Group # __________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with __________ and assign directly to Dr. Gasser 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 hereby authorize Dr. Gasser to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature

__________ __________

Relationship Date

Contact Information

Home ( ) __________ Work ( ) __________ Spouse's Work ( ) __________

Best time and place to reach you __________

IN CASE OF EMERGENCY, CONTACT (Please specify someone who does not live in your household.)

Name __________ Relationship __________

Home Phone ( ) __________ Work Phone ( ) __________

Dental History

Reason for today's visit __________

____

Former Dentist __________

City/State __________

Date of last dental visit __________

Date of last dental x-rays __________

How often do you floss? __________

How often do you brush? __________

Check any symptoms or conditions you have had:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

General Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions!

Are you under a physician's care now? Yes ☐ No ☐ n/a ☐ ____________________

Have you ever been hospitalized or had a major operation? Yes ☐ No ☐ n/a ☐ ____________________

Have you ever had a serious head or neck injury? Yes ☐ No ☐ n/a ☐ ____________________

Do you take, or have you taken, Phen-Fen or Redux? Yes ☐ No ☐ n/a ☐ ____________________

Are you on a special diet? Yes ☐ No ☐ n/a ☐ ____________________

For women, are you pregnant ☐, trying to become pregnant ☐, nursing ☐, or taking oral contraceptives ☐?

Medications

List any medications that you are currently taking, and the correlating diagnosis:

____

____

____

____

Pharmacy Name ____________________

Pharmacy Phone ____________________

Allergies

☐ Aspirin
☐ Codeine
☐ Latex
☐ Penicillin
☐ Other ____________________

☐ Barbiturates (sleeping pills)
☐ Iodine
☐ Local anesthetic
☐ Sulfa

____

____

Do you have, or have you had, any of the following symptoms or conditions?

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve*
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains

☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medication
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea

☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur*
☐ Heart Pace Maker*
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat

☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse*
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever*
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles

☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

* Condition may require medication.

Have you ever had any serious illness not listed above? Yes ☐ No ☐ n/a ☐ ____________________

Comments: ____________________

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

Signature of patient, parent, or guardian **Date**

Thank You!