CALVERT DENTISTRY
EXPERIENCE • EFFICIENCY • EXCELLENCE
Gary M. O'Shea, DDS Robert Hoerauf, DDS

WELCOME

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for your dental needs.

Date:_____

Name:_____Male_____Female_____Birthdate____-____-____
(Circle One) Mr. Mrs. Ms. Dr.

I prefer to be called:_____S.S. #_____-_____-_____ Age:_____

Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( ) Student ( ) School: _____

Home Address:_____City:_____State:_____Zip:_____

Home Phone: _____Work Phone: _____Cell/Pager:_____

Employer:_____Address:_____

Spouse's Name:_____Address:_____Phone:_____

*Person Responsible for Account: _____S.S.#_____

Address:_____Phone:_____

_____Relationship:_____

*How or by whom did you hear about our practice?_____Relationship:_____

Address:_____

In case of emergency contact: _____

Home phone: _____Work phone: _____Cell:_____

Primary Dental Insurance

Subscriber's Name_____

DOB_____Phone_____

Subscriber's Address_____

_____Zip_____

Insurance Co. Name_____

Policy or Group #_____Phone_____

I.D.# _____

Insurance Co. Address_____

_____Zip_____

Subscriber's Employer_____

Address_____

_____Zip_____

Employer Phone_____

Subscriber's Social Security #_____

Secondary Dental Insurance

Subscriber's Name_____

DOB_____Phone_____

Subscriber's Address_____

_____Zip_____

Insurance Co. Name_____

Policy or Group #_____Phone_____

I.D. # _____

Insurance Co. Address_____

_____Zip_____

Subscriber's Employer_____

Employer Address_____

_____Zip_____

Employer Phone_____

Subscriber's Social Security #_____

I hereby direct benefits payable to the attending dentist:

Signature_____**Date**_____

Continue on Second Page

Patient's Medical History

Personal Physician:_____

Phone:_____

Current Health: _____Good_____Fair_____Poor

Are you currently under the care of a physician? ____Y____N

Are you taking any prescription/over counter drugs?_____

Please list:_____

_____

Have you ever had any of the following disease or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joint/ Valves
Y N Asthma
Y N Autism
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hemophilia
Y N Heart Attack
Y N Heart Defect (Congenital)
Y N Heart Murmur
Y N Heart Pacemaker
Y N Heart Surgery
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV/AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Radiation Treatment
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)

List any serious medical conditions you may have had which are not listed.

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Penicillin
Y N Latex
Y N Other_____

_____

_____

Special concerns for our female patients

Are you pregnant? Y N Week#_____

Are you taking birth control pills? Y N

Patient's Dental History

Last Dental Visit:_____

Why have you come to the dentist today?_____

_____

Do you require antibiotics before treatment? ____Y____N

Are you currently in pain? ____Y____N

Have you ever had a serious/difficult problem associated with any previous dental work? ____Y____N

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ)? ____Y____N

Is there anything about your smile or the way your teeth look that causes you concern?

_____

Would you like whiter teeth? ____Y____N

Your current dental health is: ____Good____Fair____Poor

Do your gums bleed frequently? ____Y____N

How many times a day do you brush? _____

Type of bristles? _____Hard_____Medium_____Soft

Special concerns for the child patient

Is your child's water fluoridated? _____Y_____N

Does your child take fluoride supplements? _____Y_____N

Does/did your child have any of the following habits?

Y N Nursing Bottle Habits
Y N Thumb/Finger Sucking

I acknowledge that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my or my child's medical status.

I authorize the dental staff to perform any necessary dental service that may be needed during diagnosis and treatment with my informed consent.

I am responsible for my total obligation should dental insurance result in less coverage than anticipated.

_____

Signature Date

Thank-you for completely filling out this form. It will enable us to help you more effectively. If you have any questions at any time please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.

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I _____hereby request my records and or records of my minor child.

Name of minor child _____

Sent From: (Name, address, area code and phone number of dentist/person sending records)

_____

_____

_____

To: (Name, address, area code and phone number of dentist/person to receive records)

_____

_____

_____

I understand there may be an administrative fee applied for photo-copying pages and/or duplicating x-rays.

The fee of $ _____ was discussed with me and I agree to pay the fee upon record request.

_____ _____

Patient's Name Printed / Date Patient's Signature (Parent if minor)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____