CALVERT DENTISTRY

EXPERIENCE • EFFICIENCY • EXCELLENCE

Robert Hoerauf, DDS
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Patient Information

Date:_____

First Name:_____ Last:_____ MI_____ I prefer to be called:_____

(Circle One) Mr Mrs Ms Miss Dr.

Address:_____ City:_____ State:_____ Zip:_____

Home#:_____ Work#:_____ ext:_____ Cell#:_____

Date of Birth:_____ Sex (M)_____ (F)_____ Age:_____ S.S.#_____

Employer:_____ Address:_____

_____

E-mail:_____ May we send appointment reminders, statements, etc. via email? Yes____ No____

Spouse's Name:_____ Address:_____ Phone:_____

(If different from above)

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

Address:_____ Contact #_____ DOB_____

In case of emergency contact:_____ Hm Phone:_____ Cell:_____

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

If patient is a minor who is accompaning them today:_____ Relationship_____

Other family members seen in our office:_____

Dental Insurance

Subscriber's Name_____ D.O.B._____

Hm. Phone_____ Cell Phone_____

Subscriber's Address_____ Zip_____

*****Subscriber's Employer Name**_____ **Union #**_____

Subscriber's Employer Address_____ Zip_____

Subscriber's S.S.# or ID#_____ Employers Phone_____

Insurance Co. Name_____ Policy or Group #_____

Insurance Co. Address_____ Zip_____

Insuranc Co. Phone #_____ Effective Date_____

I understand that the information that I have given 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 childs medical status. I authorize the dental staff to perform any necessary dental service that my be needed during diagnosis and treatment with my informed consent.

I understand that I am responsible for all charges incurred regardless of my insurance status. Charges not paid within ninety (90) days by insurance will be the patient's responsibility, I further agree, in the event of default due to nonpayment, to be responsible for collection fees, court costs and/or legal fees and that there will be a fee for all returned checks. I hereby direct benefits payable to the attending dentist.

Our office is HIPPA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA. Please review the Hippa Privacy Statement located in the waiting room.

If you have any questions at any time please ask us. We are happy to help,

Signature_____ **Date**_____ **(over)**

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 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

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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)