CONFIDENTIAL PATIENT HISTORY

Patient full name_________________________________ (M or F)   Nickname________________

Address______________________________________ Apt #______ City________________

State_____ Zip _______Phone______-______-________ E-mail ______________________________

Cell Phone _____ - ______ - _______ Whose name is on your mail box? _____________________

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Patient Social Security #_____________________Patient Birth Date__________________________

Patient Employer_______________________________________ Phone # _____-_____-________

Full time student?__________ Name of School ____

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Person responsible for payments:

Name______________________________________ Relationship____________________

Address____________________________________ Apt #______ City________________

State________________ Zip____________ Phone________ - ______ -________________________

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Please give the names, addresses and phone #'s of two friends or relatives living near you.

1) ____

2) ____

I was referred to your office by____

<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<

Dental Insurance

Subscriber Name ____________________________________SS#________________________

Birth Date_______________Employer ______________________ Group # __________________

Insurance Name & Address____

We will submit a claim for you with the insurance information you provide us. **You are responsible for all charges regardless of your insurance coverage.**

I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I agree to pay all fees for such treatment the day they are incurred, unless I have made previous arrangements. I understand that any outstanding balance over 90 days will have a 1.5% per month finance charge added.

I hereby authorize payment directly to Barry D. Gerst, D.D.S., any insurance benefits otherwise payable to me.

I consent to be billed for any cancellation without a 24 hour notice.

Signature____Date_________________________

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When were your teeth last cleaned ?_____

Previous Dentist's Name_____Phone_____-_____-_____

Did your last dentist take x-rays? _____ When?_____
Have you ever had complications following Dental procedures? _____
Do you have any tooth sensitivity to hot, cold or sweet? _____
Do you like your smile? _____ How would you like to change it? _____
_____

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Indicate if your physician has ever told you that you have high or low blood pressure?_____

Do you have any of the following: Please mark **YES** or **NO**

Heart trouble	_____	Diabetes	_____	Heart Valve replacement	_____	Migraines	_____
Tuberculosis	_____	Asthma	_____	Joint replacement	_____	Cold Sores	_____
Kidney disease	_____	MS	_____	Liver disease	_____	Cancer	_____
AIDS	_____	HIV	_____	Hepatitis Type___	_____	Blood disease	_____

Please check if you are allergic or sensitive to:
Penicillin _____ Novocaine _____ Anesthetics _____ Latex _____
Any drugs _____ Please list _____
Are you allergic to anything else? _____ Please list_____

Have you had any problems with bleeding or your blood clotting? _____

Are you currently taking **ANY** medication or drugs? _____ If yes, what? _____
Examples: aspirin, birth control pills, antibiotics, etc. _____

Have you been hospitalized? _____ If yes, for what? _____

Are you currently under the care of a physician? _____ If yes, for what? (Be specific) _____
_____

Are you pregnant? _____ If yes, when are you expecting? _____

Do you use tobacco products? _____ If yes, would you like to quit? _____

Family Physician _____ Phone _____-_____-_____
Address _____

Voluntary Information

Hobbies, interest, comments _____
_____

Thank you for your time, completing this form.