## ELCON

## Patient Information Dental Insurance

Who is responsible for this account? Date Relationship to Patient SS/HIC/Patient ID # Insurance Co. Patient Name Last Name Group # First Name Middle Initial Is patient covered by additional insurance? Yes No Address Subscriber's Name E-mail Birthdate SS# City Relationship to Patient State Zip \_\_\_\_\_ Insurance Co. Age Sex M F Birthdate Group # ☐ Widowed ☐ Single ☐ Minor Married ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with Divorced Partnered for years Separated and assign directly to Name of Insurance Company(ies) Patient Employer/School Occupation all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am Employer/School Address 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 dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents Employer/School Phone ( ) for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when Spouse's Name my current treatment plan is completed or one year from the date signed below. Birthdate Signature of Patient, Parent, Guardian or Personal Representative SS# Please print name of Patient, Parent, Guardian or Personal Representative Spouse's Employer Date Whom may we thank for referring you? Relationship to Patient Phone Numbers Phone (\_\_\_\_) Work (\_\_\_) Ext \_\_\_\_ Alt.Phone (\_\_\_) Best time and place to reach you Spouse's Work ( ) IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.) Name Relationship Work Phone (\_\_\_\_\_) Phone ( **Dental History** Reason for today's visit Chew on one side of mouth Yes No Mouth breathing Yes No Cigarette, pipe, or cigar Mouth pain, brushing Yes No smoking Yes No Orthodontic treatment Yes No Former Dentist Clicking or popping jaw Yes No Pain around ear Yes No Dry mouth Yes No City/State Periodontal treatment Yes No Fingernail biting Yes No Sensitivity to cold Date of last dental visit Yes No Food collection between Sensitivity to heat Yes No Date of last dental X-rays the teeth Yes No Sensitivity to sweets Yes No Foreign objects Yes No Place a mark on "yes" or "no" to indicate if Sensitivity when biting Yes No you have had any of the following: Yes No Grinding teeth Sores or growths in your Bad breath Yes No Yes No Gums swollen or tender Yes No mouth Bleeding gums Yes No Jaw pain or tiredness Yes No How often do you floss? Blisters on lips or mouth Yes No Yes No Lip or cheek biting How often do you brush? Loose teeth or broken fillings Yes No Burning sensation on tongue Yes No Rev 10/2013 #20596 - ©Medical Arts Press 1-800-328-2179

are you over used a bisphosphonate medication? Common brand names are Fosamax, Actorel, Atelvia, Didronol, Boniva.   Vies   No zo you over taken any of the group of drugs collectively referred to as "fen-phran?" These include combinations of hommin, Adipex, Fastin rand names of phenomenine). Proving and Pedatu, (decinitarianie), Vies   No 2004 and any of the following:   DSHIV   Vies   No 2004 and any of the following:   Vies   No 2004   No 2			Health	History	/		
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and names of phentermine). Pondmin (refriturantine) and Redux (dexdenfuturantine).   Yes   No   Sacility   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of the following: DS/HIV   Secondary of "no" to indicate if you have had any of "no" to indicate if you have had any of "no" to indicate if you have had not not indicate if you have had any of "no" to indicate if you have had not not indicate if you have had not not indicate if you have had not not not indicate if you have had not							
ace a mark on "yes" or "no" to indicate if you have had any of the following:    DSHIV	Have you ever taken any of (brand names of phentermi	the group of drugs ne), Pondimin (fen	collectively referred to a cluramine) and Redux (d	as "fen-phen?" T exfenfluramine).	These inc	clude combinations of Ionimin,	Adipex, Fastin
DSH-IIV							
thritis, Rheumatism	AIDS/HIV				☐ No	Respiratory Disease	Yes No
tificial Heart Valves   Yes   No   Headaches   Yes   No   Shortness of Breath   Yes   No   No   No   No   No   No   No   N	Anemia	Yes No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes ☐ No
Inficial Joints   yes   No   Heart Murmur   yes   No   Sirus Trouble   yes   No   Allergies   No   Heart Problems   yes   No   Skin Rash   yes   No   No   No   Stroke   yes   No   Stroke   yes   No   Skin Rash   yes   No   No   No   No   No   Skin Rash   yes   No   No   No   No   No   No   No   N	Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes ☐ No
sithma	Artificial Heart Valves		Headaches	Yes	☐ No	Shortness of Breath	☐ Yes ☐ No
Comparison   Com	Artificial Joints			☐ Yes	☐ No	Sinus Trouble	Yes No
Herpes   Herpes   Wes   No   Months   Wes   Month	Asthma			W-365000	-		3 15 U
Attactions or surgery		Yes No		The state of the s	100	*/	
Swollen Neck Glands   Pes   No   Jaundice   No   Swollen Neck Glands   Pes   No   No   Jaundice   No   Swollen Neck Glands   Pes   No   No   Jaundice   No   No   No   No   No   No   No   N		Yes No	•	20, 20, 00, 000			
ancer   Yes   No   Jaw Pain   Yes   No   Jaw Pain   Yes   No   No   Normical Dependency   Yes   No   Normical Problems   Yes   No   Normical Prob	Blood Disease	A STATE OF THE STA		2000000			
remical Dependency   Yes   No   No   Kidiney Disease   Yes   No   Tonsilitis   Yes   No   No   Yes   No   No   No   No   No   No   No   N	Cancer			25 (0.000)			
remotherapy	Chemical Dependency	Service and the service and th		-		Service Commission Com	100000000000000000000000000000000000000
routatory Problems	Chemotherapy			200	100000000000000000000000000000000000000		
Mitral Valve Prolapse   Yes   No   Or neck   Yes   No   Nor neck   Yes   No   Northsone Treatments   Yes   No   Northsone Treatment   Yes   Northsone Tre	Circulatory Problems	Yes No					_ 100 _ 140
prisone Treatments	Congenital Heart Lesions	☐ Yes ☐ No		22-079723			Yes No
abetes	Cortisone Treatments		NA - 19	Yes	☐ No	Ulcer	☐ Yes ☐ No
mphysema			Pacemaker	Yes	☐ No	Venereal Disease	☐ Yes ☐ No
ormen: e you pregnant?	Diabetes		Psychiatric Care	Yes	☐ No	Weight Loss, unexplained	Yes No
e you pregnant?				Yes	☐ No		
e you pregnant?	90 you wear contact lenses	, les	NO				
Medications st any medications you are currently taking and the correlating agnosis:    Allergies     Aspirin	Women:						
Allergies st any medications you are currently taking and the correlating agnosis:    Aspirin   Local Anesthetic     Barbiturates (Sleeping pills)   Penicillin     Codeine   Sulfa     Iddine   Other     Latex     Date     If so, what?     If so	And the second of the second o	-	Individual Resident Control Contro			Are you nursing?	☐ Yes ☐ No
agnosis:    Aspirin		Yes	_ INO				
Aspirin						Allergies	
Barbiturates (Sleeping pills) Penicillin Codeine Sulfa I odine Latex  Updates (To be filled in at future appointments) as there been any change in your health since your last dental appointment? Yes No are what conditions? If so, what?  Date Dotor's Signature Date  se you taking any new medications? If so, what?		e currently taking a	ind the correlating	Aspirin		□ Local Anesthetic	
Codeine	alagricolo.						
lodine   Other   Dotter   Latex				Barbiturate	s (Sleep	oing pills) Penicillin	
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Updates (To be filled in at future appointments) as there been any change in your health since your last dental appointment?	Pharmacy Name						
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