Platte Dental Clinic

Name: _____
Last First MI

Maiden Name: _____Preferred Name: _____ ☐ Male ☐ Female ☐ Single ☐ Married

Address: _____ City: _____ State_____ Zip_____

SSN: _____ DOB: ____/_____/_____ Employer_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____

How did you hear about our office? _____

Dental Insurance-Primary

Policy Holder Name: _____

Policy Holder DOB: _____/_____/_____

Policy Holder SSN: _____

ID Number: _____

Policy Holder Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

_____

Insurance Company Phone: _____

Group Number: _____

Payor ID Number: _____

Dental Insurance-Secondary

Policy Holder Name: _____

Policy Holder DOB: _____/_____/_____

Policy Holder SSN/ID: _____

ID Number: _____

Policy Holder Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

_____

Insurance Company Phone: _____

Group Number: _____

Payor ID Number: _____

Assignment and Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I, undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Platte Dental Clinic, LLC all insurance benefits, if any, otherwise payable to me for services rendered.

Responsible Party Signature: _____

Relationship to Patient: _____ **Date**: _____

Platte Dental Clinic

Medical History

Allergies

- ☐ Penicillin or other Antibiotics
- ☐ Dental Anesthetics
- ☐ Morphine/Codeine/Hydrocodone
- ☐ Acrylics
- ☐ Latex
- ☐ Other:

_____

Please check all that apply:

- ☐ Artificial Joint
- ☐ Artificial Heart Valve
- ☐ Congenital Heart Defects
- ☐ Endocarditis
- ☐ Heart Attack
- ☐ Stroke
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Angina
- ☐ Heart Failure
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Blood Disorder
- ☐ HIV/AIDS
- ☐ Asthma
- ☐ Tobacco Use
- ☐ Emphysema
- ☐ COPD
- ☐ Tuberculosis
- ☐ Sinus Problems
- ☐ Diabetes
- ☐ Liver Diseases/Disorders
- ☐ Kidney Diseases/Disorders
- ☐ Stomach Diseases/Disorders
- ☐ Thyroid Diseases/Disorders
- ☐ Narrow-Angle Glaucoma
- ☐ Epilepsy/Seizures
- ☐ Psychiatric Problems
- ☐ Anxiety
- ☐ Alcohol/Drug Addiction
- ☐ Cancer
- ☐ Radiation Treatment/Chemotherapy
- ☐ Pregnant
- ☐ Nursing
- ☐ Other _____

☐ Have you ever taken bisphosphonates – medications to treat osteoporosis or other bone disorders? - Yes - No

☐ In the last 2 years have you taken corticosteroids (prednisone, methylphednisolone etc.)? - Yes - No

Please list all medications:

_____

_____

_____

_____

Please list all surgeries:

_____

_____

_____

Signature:_____ Date:_____