

PATIENT INFORMATION

Name _____ ID#/SS# _____ DOB _____ Sex M F
Last First Middle Initial month / day / year

Address _____ City _____ State _____ Zip _____ - _____

Home Ph _____ Work Ph _____ Mobile Ph _____ E-mail _____

Single ___ Married ___ Name of Spouse _____ Closest Relative _____ Phone _____

Occupation _____ Employer (or school if full time student) _____

In case of emergency who should be notified? _____ Phone 1 _____ Phone 2 _____

If you are completing this form for another person, what is your relationship to that person? _____

Person Responsible for Account _____ Referred by _____

PRIMARY DENTAL INSURANCE

Subscriber Name _____ ID# _____ DOB _____ Sex M F
Last First Middle Initial subscriber # or SS # month / day / year

Address _____ City _____ State _____ Zip _____ - _____
(if different from patient's)

Home Ph _____ Work Ph _____ Mobile Ph _____ E-mail _____

Occupation _____ Employer _____

Business Address _____ City _____ State _____ Zip _____ - _____

Insurance Carrier _____ Group Name _____ Group Number _____

SECONDARY DENTAL INSURANCE

Subscriber Name _____ ID# _____ DOB _____ Sex M F
Last First Middle Initial subscriber # or SS # month / day / year

Address _____ City _____ State _____ Zip _____ - _____
(if different from patient's)

Home Ph _____ Work Ph _____ Mobile Ph _____ E-mail _____

Occupation _____ Employer _____

Business Address _____ City _____ State _____ Zip _____ - _____

Insurance Carrier _____ Group Name _____ Group Number _____

AUTHORIZATION

**I hereby authorize the release of all information necessary to secure payment of insurance benefits.
 I authorize the use of the signature below on all insurance submissions.**

Required For Assignment of Insurance Benefits: I authorize payment directly to the dentist of the insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges not paid to the dentist by my insurance carrier. I authorize Dr. Hersh to keep my credit card information on file and to charge my credit card listed below for all balances of charges not paid by my insurance carrier within 90 days of claims submission.

Visa MC Amex Discover Card# _____ Exp. ____/____

Cardholder Name _____

Signature _____ Date _____

Payment is due in full at the time of treatment unless other arrangements have been made.

DENTAL HISTORY

Date of last dental care _____ Date of last dental x-rays _____ Chief Complaint _____

Former dentist _____ Address _____ City _____ State _____ Zip _____

Check if you have or have had any of the following:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food collects between teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to biting |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores in your mouth |
| <input type="checkbox"/> Broken teeth or fillings | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Sensitivity to hot | <input type="checkbox"/> "TMJ" or jaw muscle pain |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Tumors in your mouth |

Do you smoke or chew tobacco? Y N Approximately how many cigarettes a day? _____

How often do you brush your teeth? _____ Electric or Manual toothbrush? _____ How often do you floss? _____

If you could change your teeth / smile, what would be the first thing you would want to change? _____

The second? _____ Other? _____

MEDICAL HISTORY

Physician's Name _____ Address _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate date _____ Are you wearing contact lenses? Y N

Do you have any bleeding disorders? Y N If yes, describe _____ Are you taking blood thinners, or daily aspirin? Y N

(Women) Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check if you have or have had problems with any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergies, hay fever | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Corticosteroid treatments | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV infection or AIDS | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diarrhea, persistent | <input type="checkbox"/> Immune System problems | <input type="checkbox"/> Skin disorders or rash |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Epilepsy or other neurological | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Bulimia or anorexia | <input type="checkbox"/> Fainting spells or seizures | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Health problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Gout | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |

Are you allergic or have you had a negative reaction to:

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Barbiturates or sedatives | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin / other antibiotics | <input type="checkbox"/> Other _____ |

List any medications you are taking, including non-prescription medicine: _____

I certify that I have read and understand the above. I have answered the questions to the best of my ability, and I have not knowingly made any errors or omissions in completing this form. I will not hold my dentist, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient _____ Date _____

Signature of Dentist _____ Date _____