



PATIENT INFORMATION

Patient Name _____

Address _____

City, State, Zip Code _____

E-Mail _____

Home Phone _____

Cell Phone _____

Work Phone _____

Preferred means of contact for Appointment Reminders

Home Phone Cell Phone Work Phone

Text Message E-Mail

SSN _____

Sex Male Female

Date of Birth _____

Married Widowed Single Minor

Separated Divorced Partnered for ___ years

Patient Employer/School _____

Occupation _____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name _____

Relationship _____

Phone _____

Who is Responsible for This Account? _____

Relationship to Patient _____

Address (if different) _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Name of Insured _____

Date of Birth _____ SSN _____

Name of Employer _____

Insurance Company _____

Insurance Co. Address _____

City, State, Zip Code _____

Group # _____

Policy/ID # _____

SECONDARY INSURANCE

*Please note we do not accept Medicaid as a Secondary Insurance

Name of Insured _____

Date of Birth _____ SSN _____

Name of Employer _____

Insurance Company _____

Insurance Co. Address _____

City, State, Zip Code _____

Group # _____

Policy/ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-listed Insurance Company(ies) and assign directly to Dr. Hubble V. Reichert all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance.

Dr. Reichert may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian, or Personal Representative

Date

Relationship to Patient

DENTAL HISTORY

Reason for Today's Visit _____

Date of Last Dental Exam _____

Previous Dentist _____

Date of Last Dental X-Rays _____

How often do you brush? _____

How often do you floss? _____

Place a mark on Yes or No to indicate if you have experienced any of the following:

Bad breath Yes No
 Bleeding gums Yes No
 Blisters on lips or mouth Yes No
 Burning sensation on tongue Yes No
 Chew on one side of mouth Yes No
 Cigarette, pipe, or cigar smoking Yes No
 Clicking or popping jaw Yes No
 Dry mouth Yes No

Fingernail biting Yes No
 Food collection between teeth Yes No
 Grinding teeth Yes No
 Gums swollen or tender Yes No
 Jaw pain or tiredness Yes No
 Lip or cheek biting Yes No
 Loose teeth or broken fillings Yes No
 Mouth breathing Yes No
 Orthodontic treatment Yes No

Pain around ear Yes No
 Periodontal treatment Yes No
 Sensitivity to cold Yes No
 Sensitivity to heat Yes No
 Sensitivity to sweets Yes No
 Sensitivity to biting Yes No
 Sores or growths in your mouth Yes No
 Thumb sucking Yes No

Office Use Only
 CC: _____

HEALTH HISTORY

Physician's Name _____

Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as Bisphosphonates? These include medications for osteoporosis such as Boniva, Fosamax, Didronel, Aredia, Actonel, Zometa, and Reclast. Yes No

Are you currently pregnant or nursing? Yes No

Place a mark on Yes or No to indicate if you have experienced any of the following:

AIDS/HIV Yes No
 Anemia Yes No
 Arthritis/Rheumatism Yes No
 Artificial Heart Valves Yes No
Artificial Joints Yes No
Asthma Yes No
 Back Problems Yes No
Bleeding abnormally Yes No
 Blood disease Yes No
 Cancer Yes No
 Chemical/Alcohol Dependency Yes No
Chemotherapy Yes No
 Circulatory Problems Yes No
 Colitis Yes No
 Congenital Heart Lesions Yes No
 Cortisone Treatments Yes No
 Cough, persistent or bloody Yes No
Diabetes Yes No
 Emphysema Yes No

Epilepsy/Seizure Disorder Yes No
 Fainting or Dizziness Yes No
 Glaucoma Yes No
 Hay Fever Yes No
 Headaches Yes No
 Heart Murmur Yes No
Heart Attack Yes No
 Hepatitis Type _____ Yes No
 Herpes/Cold Sores Yes No
High Blood Pressure Yes No
 Jaundice Yes No
 Jaw Pain Yes No
 Kidney Disease Yes No
 Liver Disease Yes No
 Low Blood Pressure Yes No
 Mitral Valve Prolapse Yes No
 Nervous Problems Yes No
Osteoporosis Yes No
 Pacemaker Yes No

Psychiatric Care Yes No
Radiation Treatment Yes No
 Respiratory Disease Yes No
 Rheumatic Fever Yes No
 Scarlet Fever Yes No
 Shingles Yes No
 Shortness of Breath Yes No
 Sinus Trouble Yes No
 Skin Rash Yes No
 Special Diet Yes No
 Stroke Yes No
 Swollen Feet or Ankles Yes No
 Swollen Neck or Glands Yes No
 Thyroid Problems Yes No
 Tonsillitis Yes No
Tuberculosis Yes No
 Tumor or growth on head/neck Yes No
 Ulcer Yes No
 Weight loss, unexplained Yes No

MEDICATIONS

Please list any medications you are currently taking and the correlating diagnosis.

Preferred Pharmacy _____

ALLERGIES

Aspirin Metals or Jewelry
 Barbituates (Sleeping pills) Penicillin
 Codeine Sulfa
 Dental Anesthetics Other _____
 Latex _____