

**Raben Dentistry  
Patient Information**

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last First Initial

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City St. Zip

Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_ Birthdate \_\_\_\_\_

Sex  M  F Marital Status  Single  Married  Child

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Emergency Contact Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Financial Information**

Person Responsible for this account \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Last First Initial

Employer (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

If patient is a child, the child resides with: \_\_\_\_\_ *If child's residence is different from above, please list on the back side.*

**Insurance Assignment and Release**

I, the undersigned, certify that I (or my dependent) has insurance coverage with \_\_\_\_\_ insurance company, and assign directly to Raben, D.D.S., P.A. 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, AND THAT ANY CO-PAYMENTS OR NON-COVERED SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. I understand that my insurance will be filed at no charge for the first filing. Additional requests from myself or my insurance company may be assessed an administrative charge. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

**Financial Agreement**

I understand that I am financially responsible for all charges incurred for treatment or myself of my dependent. I UNDERSTAND THAT ALL FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED, AND AGREE TO MAKE PAYMENT BY CASH, CHECK OR BANK CARD. Finance charge: Payment is due when services are rendered. A FINANCE CHARGE will be charged on all past due accounts. The FINANCE CHARGE is 1.5% per month, which is an ANNUAL PERCENTAGE RATE of 18%. There is a \$1.00 per month minimum FINANCE CHARGE for accounts not paid in full. All returned checks will be assessed a \$30.00 service charge. **Your appointments in our office are times that we reserve just for you. Appointments broken within 24 hours of the appointment time may be assessed a broken appointment fee.**

Signature of Responsible party \_\_\_\_\_ Date \_\_\_\_\_

# Patient History

Patient Name \_\_\_\_\_

## Dental History

Describe your overall dental health \_\_\_\_\_ What are your dental concerns? \_\_\_\_\_

Previous dentist \_\_\_\_\_ Last dental exam \_\_\_\_\_

Do you have x-rays that you would like us to request?  Y  N

Have you been satisfied with your previous dental care?  Y  N Why? \_\_\_\_\_

**Check (✓) if you have had problems or concerns with any of the following:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding/clenching teeth           | <input type="checkbox"/> Sensitivity to hot      | <input type="checkbox"/> Sores in mouth |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Loose teeth/broken fillings        | <input type="checkbox"/> Sensitivity to cold     | <input type="checkbox"/> Yellow teeth   |
| <input type="checkbox"/> Clicking/popping jaw          | <input type="checkbox"/> Nervousness about dental treatment | <input type="checkbox"/> Sensitivity to sweets   |   |
| <input type="checkbox"/> Food collection between teeth |   | <input type="checkbox"/> Sensitivity when biting |   |

How often do you brush \_\_\_\_\_ How often do you floss \_\_\_\_\_ Do you like the appearance of your teeth \_\_\_\_\_

What would you like to change about your smile? \_\_\_\_\_

**Check (✓) if you have or have had any of the following:**

- |  |                                       |   |   |  |
|--|---------------------------------------|---|---|--|
| <input type="checkbox"/> Treatment for TMJ | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Root Canal Therapy | <input type="checkbox"/> Dentures or Partials | <input type="checkbox"/> Periodontal treatment |
|--|---------------------------------------|---|---|--|

## Medical History

Physician's Name \_\_\_\_\_ Last Physical Exam \_\_\_\_\_ Describe your overall Health? \_\_\_\_\_

Any overall health changes in the past year?  Y  N If yes, please describe \_\_\_\_\_

Have you been hospitalized in the past 2 years?  Y  N If yes, please describe \_\_\_\_\_

Are you currently under medical care?  Y  N If yes, please describe \_\_\_\_\_

Have you ever taken **Fen-Phen/Redux**?  Y  N

Have you ever been told to **Pre-medicate** before dental procedures?  Y  N Why? \_\_\_\_\_

Please **CIRCLE** (Y) or (N) if you **NOW HAVE** or **HAVE EVER HAD** any of the following conditions listed below:

Heart Trouble	Y N	Fainting or Dizziness	Y N	Ulcers	Y N	Drug Addiction	Y N
Heart Murmur	Y N	Stroke	Y N	Sinus Trouble	Y N	Substance Abuse	Y N
Artificial Heart Valve	Y N	Lung Disease	Y N	Hay Fever	Y N	Psychiatric Care	Y N
Heart Pacemaker	Y N	Asthma	Y N	Allergies	Y N	Dental Treatment fear	Y N
Heart Surgery	Y N	Tuberculosis	Y N	Arthritis	Y N	Artificial Joint	Y N
Cardiovascular Disease	Y N	Emphysema	Y N	Immune System Depression		Seizure Disorder	Y N
High/Low Blood Pressure	Y N	Kidney Disease	Y N	(organ transplant, cancer or		Pain in Jaw Joints	Y N
Blood Disease	Y N	Liver Disease	Y N	AIDS)	Y N	Thyroid Disease	Y N
Bleeding Disorder	Y N	Hepatitis	Y N	HIV Positive	Y N	Cancer	Y N
Blood Transfusion	Y N	Excessive Thirst	Y N	Cold sores	Y N	Radiation Treatments	Y N
Hemophilia	Y N	Diabetes	Y N	Herpes	Y N	Chemotherapy	Y N
Pain in Chest (Upon Exertion)	Y N	Hypoglycemia	Y N	Glaucoma	Y N		

Are you **CURRENTLY** taking any medications?

Prescription medications \_\_\_\_\_

Over the counter medications \_\_\_\_\_

Herbal supplements \_\_\_\_\_

Vitamins or Minerals \_\_\_\_\_

Recreational drugs \_\_\_\_\_

*Please list additional medications on the back of the form*

Are you **ALLERGIC** to, or ever had a **REACTION** to, the following

Local Anesthetics (Novacaine, etc.) \_\_\_\_\_

Antibiotics \_\_\_\_\_

Asprin or anti-inflammatory drugs \_\_\_\_\_

To any medications \_\_\_\_\_

Do you wish to talk privately about any problem?  Y  N

Do you have ANY disease, condition, or problem not listed anywhere on this form?  Y  N

*If yes, please describe on the back of the form*

I confirm that this dental and medical history accurately describes my past and current conditions.

\_\_\_\_\_  
Patient or Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed

*Please list all medications including prescriptions, over the counter, herbal supplements, vitamins or minerals or recreational drugs.*

**Medications**

**Herbs**

**Vitamins/Minerals**

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*Please list any additional problems or concerns that you may have*

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