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:

□ Bad Breath	□ Grinding/clenching teeth	□ Sensitivity to hot	□ Sores in mouth
□ Bleeding Gums	□ Loose teeth/broken fillings	□ Sensitivity to cold	□ Yellow teeth
□ Clicking/popping jaw	□ Nervousness about dental	□ Sensitivity to sweets	
□ Food collection between teeth	treatment	□ 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:

□ Treatment for TMJ □ Orthodontics □ Root Canal Therapy □ Dentures or Partials □ 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 Reviewd

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

Medications	**Herbs**	**Vitamins/Minerals**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any additional problems or concerns that you may have

_____
_____
_____
_____