Today's Date_______________

Dewitt Dentistry Patient Information (Confidential)

Patient Name_______________________________________Date of Birth______________Social Security #________________

Address____City____________________State________Zip____________

Home Phone_________________________ Cell Phone_________________________E-Mail____________________________

Minor____Single____Married____Divorced____Widowed____Seperated____ Spouse/Parent Name__________________________________

Employer__________________________Work Phone____________________Employer Address__________________________

Spouse/Parent Employer__________________________________Employer Address_____________________________________

Work Phone_________________________Who referred you? ____

**Emergency Contact__________________________Relationship:______________________Phone #__________________

Permission to contact you by e-mail: YES NO Permission to leave messages on answering device: YES NO

Permission to relay confidential information to: ____

PRIMARY INSURANCE

Employee Name_____________________D.O.B.___________

Employer Name____

SS# of Insured____

Name of Insurance Company______________________________

Address of Ins. Co.____________________________________

Phone________________________ Policy #______________

Union Local or Group Name______________________________

SECONDARY INSURANCE

Employee Name_____________________D/O/B___________

Employer Name____

SS# of Insured____

Name of Insurance Company______________________________

Address of Ins. Co. ____________________________________

Phone________________________ Policy#______________

Union Local or Group Name______________________________

*****YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR EMPLOYER. IT IS IMPOSSIBLE FOR US TO KNOW EVERY PATIENTS POLICY AS ALL OF THEM DIFFER. ANY CLAIM NOT COVERED FOR ANY REASON IS YOUR RESPONSIBILITY. (ie: Missing tooth clause, waiting periods, non covered procedures, implants, etc.) IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE COMPANY AND SEE WHAT YOUR POLICY PROVISIONS ENTAIL. Please initial here:*** ____________________

PATIENT MEDICAL HISTORY

Primary Care Physician: _________________________Phone:____________________Address________________________

Last Exam________________Are you currently being treated? ___________What is being treated? ___________________

Have you ever been hospitalized for any surgery or illness? YES NO If **yes** what was the problem____________________

____

List any medications you are currently taking (prescription OR OTC) ____

____

Are you in good health? YES NO Have there been any changes in your health in the past year? YES NO

If yes, what has changed? ____

Do you have any of the following conditions?

Condition			Condition		
High Blood Pressure	YES	NO	Heart Disease	YES	NO
Stroke	YES	NO	Cardiac defibrillator/Pace Maker	YES	NO
Chest Pains	YES	NO	Heart Murmur	YES	NO
Heart Attack	YES	NO	Valve replacement therapy	YES	NO
Rheumatic fever	YES	NO	Mitral Valve prolapse	YES	NO
Anemia	YES	NO	Are you on aspirin therapy	YES	NO
Are you on blood thinners	YES	NO	Frequently Tired	YES	NO
Swollen Ankles	YES	NO	Fainting/Dizziness	YES	NO
Easily Winded	YES	NO	Asthma	YES	NO
Migraine Headaches	YES	NO	Epilepsy/seizures	YES	NO

OVER →

Arthritis	YES	NO	Allergy to latex products	YES	NO
Hay fever/Allergies	YES	NO			
Allergies to medications	YES	NO	If yes please list______________________________		

Emphysema	YES	NO	Tuberculosis	YES	NO
Chronic Bronchitis	YES	NO	Thyroid Problems	YES	NO
Diabetes	YES	NO	Glaucoma	YES	NO
Joint replacement/implant	YES	NO	Organ Transplant	YES	NO
Leukemia	YES	NO	Cancer	YES	NO
Radiation Therapy	YES	NO	Chemotherapy	YES	NO
Hepatitis/Jaundice/Liver disease	YES	NO	Colon Disease	YES	NO
Mononucleosis	YES	NO	Diverticlate disease	YES	NO
Peptic Ulcer	YES	NO	Reflux esophagitis	YES	NO
Kidney Disease	YES	NO	Sexually transmitted disease	YES	NO
Prostate Disease	YES	NO	AIDS or HIV Infection	YES	NO
Are you wearing contact lenses?	YES	NO	Do you have hearing difficulties?	YES	NO

Do you smoke? YES NO How much? __________ Frequency of Alcohol consumption__________________________

WOMEN ONLY

Are you pregnant, think you may be? YES NO If yes, when is your due date? ______________________

Are you nursing?	YES	NO	Estrogen Replacement Therapy	YES	NO
Are you taking Birth Control Pills?	YES	NO	Medication for Osteoporosis?	YES	NO

DENTAL HISTORY

Do your gums bleed while brushing?	YES	NO	Are your teeth sensitive to hot/cold?	YES	NO
Are your teeth sensitive to sweet/sour?	YES	NO	Do you have any sores in or near your mouth?	YES	NO
Have you had any neck or jaw injuries?	YES	NO	Do you clench or grind your teeth?	YES	NO
Do you have frequent headaches?	YES	NO	Have you ever had a difficult extraction?	YES	NO
Do you bite your lips/cheeks frequently?	YES	NO	Have you ever had orthodontic work?	YES	NO
Ever experienced clicking in your jaw?	YES	NO	Ever had difficulty in opening/closing mouth?	YES	NO
Ever experience pain (joint,ear,side of face)?	YES	NO	Difficulty Chewing?	YES	NO

Are you wearing removable dental appliances?	YES	NO
Have you ever had instructions on how to care for your teeth?	YES	NO
Have you ever had instructions on how to care for your gums?	YES	NO

What is your chief dental complaint? ____

Authorization and Release

Consent to examination and treatment

I herby give my consent for the above named patient to receive dental examinations and diagnostic procedures with Wm. E. DeWitt D.D.S., P.C. Such examination and treatment may include, but shall not be limited to, all necessary procedure including the use of anesthesia deemed advisable by the dental staff in the exercise of their professional judgment.

Assignment of insurance benefits & guaranty of payment

In consideration of the professional care provided to the above named patient, I herby assign, transfer and set over to any dental reimbursement under my insurance policy or health benefit indemnification agreement payable to me for services rendered by Wm. E. DeWitt D.D.S., P.C.

I understand that I will be fully responsible for payment of any and all charges not covered by insurance at the current rates established by Wm. E. DeWitt D.D.S.; P.C. for all services rendered the above patient from date hereof and thereafter. I further understand that I shall be responsible for any expense of Wm. E. DeWitt D.D.S., P.C. in collecting the amounts guaranteed herby, including all costs of collection, reasonable attorney's fees and costs and all other collection expenses. Finance charges at 1-1 ½% per month (18% annum) shall be applied to accounts with open balances after 30 days of service rendered.

Authorization for disclosure of information

I herby authorize Wm. E. DeWitt D.D.S., P.C. to release all medical and dental information that may be necessary for the payment on my behalf of the health care services rendered to the above named patient.

Signature____ Date____________________