



Remmers Dental Group

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## Confidential Patient Information – I

*(Please Print Legibly)*

Date: \_\_\_\_\_

### Personal Information

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Home#: \_\_\_\_\_ Work #: \_\_\_\_\_ Mobile #: \_\_\_\_\_

E-mail: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: M F

Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Referred By: \_\_\_\_\_

### Person Responsible for Account

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Home # \_\_\_\_\_ Work#: \_\_\_\_\_ Mobile#: \_\_\_\_\_

### Dental Insurance Information

Primary Insurance Co: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Employee with Ins: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_

Birthdate of Policy Holder: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy #: \_\_\_\_\_

*I understand that payment is my obligation regardless of insurance or any other third party involvement.*

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Confidential Patient Information-II

Name \_\_\_\_\_ Date \_\_\_\_\_

Have you been hospitalized in the last 5 years? (Please circle) No    Yes

If yes, reason: \_\_\_\_\_

Are you currently receiving care? No    Yes If yes, nature of care: \_\_\_\_\_

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. \_\_\_\_\_
2. \_\_\_\_\_

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes

Have you been told by a doctor to take antibiotics before dental treatment? No    Yes

Women: Are you pregnant? No    Yes  
 If no, are you planning a pregnancy in the near future? No    Yes  
 Are you a nursing mother? No    Yes  
 Are you taking birth control pills? No    Yes

Abnormal Blood Pressure? (Please circle) No    Yes  
 If yes, what is it usually:    S            /D

Are you allergic or have you had a reaction to:

- a. Local anesthetics ..... No    Yes
- b. Penicillin or other antibiotics ..... No    Yes
- c. Aspirin ..... No    Yes
- d. Codeine, valium or other sedatives..... No    Yes
- e. Other \_\_\_\_\_

Are you a smoker? No    Yes  
 If so, how much do you smoke per day? \_\_\_\_\_

Please list any medications you are currently taking:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.*

\_\_\_\_\_  
*Patient (Print Name)*                      *Patient Signature*                      *Date*

\_\_\_\_\_  
*Reviewed by (print name)*                      *Reviewed by (signature)*                      *Date*

As part of your first visit with us, we want to give you the best treatment possible. To properly diagnose your overall condition and complete a comprehensive exam, our policy is to obtain a series of radiographs (x-rays) of your entire mouth. If you have dental insurance, they may not pay the entire fee for these x-rays. If you have had a recent panoramic x-ray (within the last 3 years), please inform the staff. If you have any questions about your coverage, our administrative staff will be happy to assist you.

*I have read the above policy regarding x-rays for my comprehensive exam. I understand that I am responsible for any charges not covered by my dental insurance.*

Patient Signature \_\_\_\_\_  
(parent if patient is a minor)

Date \_\_\_\_\_

**DOCTOR'S USE ONLY**

Comments on patient interview concerning medical history:

\_\_\_\_\_  
Dental management considerations:  
\_\_\_\_\_

\_\_\_\_\_  
*Doctor (Print Name)*                      *Doctor Signature*                      *Date*