Welcome...

E. John Baron DDS A PROFESSIONAL DENTAL CORPORATION
GENERAL AND COSMETIC DENTISTRY

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help you.

Patient Information (CONFIDENTIAL)

Date _____

Drivers Lic. # _____ Soc. Sec. # _____

Name _____ Birthdate _____
FIRST MIDDLE LAST

Home Phone _____ Cell Phone _____ E-mail _____

Address _____ City _____ State _____ Zip _____

Employed by _____ Occupation _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Female ☐ Male Is Patient: ☐ Married ☐ Single ☐ Child

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Person to Contact in Case of Emergency _____ Phone _____

Whom may we thank for referring you? _____

Responsible Party / Primary Insurance Information

Name of Person Responsible for this Account _____
FIRST MIDDLE LAST

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Work Phone _____

Insurance Company _____ Group # _____

Drivers License # _____

Spouse or Secondary Insurance Information

Drivers License # _____

Is Patient Covered by Insurance?: ☐ Yes ☐ No Soc. Sec. # _____

Name _____ Relation to Patient _____ Birthdate _____
FIRST MIDDLE LAST

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Dental History

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of Last Dental Care _____ *Date of Last Dental X-Rays* _____

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

- ☐ *Bad Breath*
- ☐ *Bleeding Gums*
- ☐ *Clicking or Popping Jaw*
- ☐ *Food Collection Between Teeth*
- ☐ *Grinding Teeth*
- ☐ *Loose Teeth or Broken Fillings*
- ☐ *Periodontal Treatment*
- ☐ *Sensitivity to Cold*
- ☐ *Sensitivity to Hot*
- ☐ *Sensitivity to Sweets*
- ☐ *Sensitivity when Biting*
- ☐ *Sores or Growths in your Mouth*

How often do you floss? _____ *How often do you brush?* _____

Medical History

Physician's Name _____ *Date of Last Visit* _____

Have you had any serious illnesses or operations? ☐ *Yes* ☐ *No* *If yes, describe* _____

Have you ever had a blood transfusion? ☐ *Yes* ☐ *No* *Have you taken Phen Fen?* ☐ *Yes* ☐ *No*

(Women) Are you pregnant? ☐ *Yes* ☐ *No* *Nursing?* ☐ *Yes* ☐ *No* *Taking Birth Control Pills?* ☐ *Yes* ☐ *No*

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

- ☐ *AIDS*
- ☐ *Anemia*
- ☐ *Arthritis, Rheumatism*
- ☐ *Artificial Heart Valves*
- ☐ *Artificial Joints*
- ☐ *Asthma*
- ☐ *Back Problems*
- ☐ *Blood Disease*
- ☐ *Cancer*
- ☐ *Chemical Dependency*
- ☐ *Chemotherapy*
- ☐ *Circulatory Problems*
- ☐ *Cold Sore/Fever Blister*
- ☐ *Cortisone Treatments*
- ☐ *Cough, Persistent*
- ☐ *Cough up Blood*
- ☐ *Diabetes*
- ☐ *Epilepsy*
- ☐ *Fainting*
- ☐ *Glaucoma*
- ☐ *Headaches*
- ☐ *Heart Murmur*
- ☐ *Heart Problems*

  *Describe*_____
- ☐ *Hemophilia*
- ☐ *Hepatitis*
- ☐ *High Blood Pressure*
- ☐ *HIV Positive*
- ☐ *Jaw Pain*
- ☐ *Kidney Disease*
- ☐ *Liver Disease*
- ☐ *Mitral Valve Prolapse*
- ☐ *Nervous Problems*
- ☐ *Pacemaker*
- ☐ *Psychiatric Care*
- ☐ *Radiation Treatment*
- ☐ *Respiratory Disease*
- ☐ *Rheumatic Fever*
- ☐ *Scarlet Fever*
- ☐ *Shortness of Breath*
- ☐ *Skin Rash*
- ☐ *Stroke*
- ☐ *Swelling of Feet or Ankles*
- ☐ *Thyroid Problems*
- ☐ *Tobacco Habit*
- ☐ *Tonsillitis*
- ☐ *Tuberculosis*
- ☐ *Ulcer*
- ☐ *Disease or Condition not Listed*_____

MEDICATIONS

List Medications you are currently taking

_____

_____

_____

ALLERGIES

- ☐ *Penicillin*
- ☐ *Local-Anesthetic*
- ☐ *Latex*
- ☐ *Any Other* _____

Authorization and Release

Our office requires a 24-Hour Notice to change an appointment.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*Patient's Signature or Signature if Minor*_____ *Date*_____