MIDWESTERN DENTAL

PATIENT INFORMATION

PATIENT NAME:	( ) Male ( ) Female	DATE OF BIRTH:	
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE:	S.S.#:	
PERSON TO CONTACT IN CASE OF EMERGENCY:		PHONE:	
HOW DID YOU HEAR ABOUT US?	DRIVER LICENSE #:		

INSURANCE INFORMATION

If you would like us to submit your claims for services directly to your Dental Insurance Company (Including Midwestern Dental Plans). You must provide information about all dental benefit programs that could cover the patient. If you would prefer to pay for the services yourself and be reimbursed by your Insurance you need not complete this section.

Please print the following information for the person who has the dental insurance:

		Additional Dental Insurance (If covered by)
What dental insurance do you have?		
Dental insurance group #:		
Dental insurance phone #:		
Where do you work?		
Work phone number:	( )	( )
Employee name who has dental insurance:		
Date of birth of insurance holder:		
Social security number of insurance holder:		
Union / Local Number:		
Are you hourly or salary?		
Are you working or retired?		

Who is responsible for this account: ______________________________

SIGNATURE AUTHORIZATION: I hereby authorize Midwestern Dental to execute in my name all payment application forms for treatment. The determination of Midwestern Dental as treatment rendered shall be conclusive. I also authorize Midwestern Dental to sign my name to their computer insurance forms when processing my account for payments.

SIGNATURE OF DENTAL INSURANCE HOLDER	DATE

FOR OFFICE USE ONLY

Patient Eligibility: Benefit 1 ( ) YES ( ) NO Date____________ Benefit 2 ( ) YES ( ) NO Date____________

Person At Insurance Company	M / W Employee Initials	Picture I.D. Verified

MIDWESTERN DENTAL

PATIENT DENTAL HISTORY

PREVIOUS DENTIST:	DATE OF LAST DENTAL EXAM:

YES
( ) Are you or have you recently been experiencing pain in your mouth or face?
( ) Do you have any dental condition(s) which you believe requires immediate attention today?
( ) Have you experienced an unusual reaction to a local anesthetic (novocaine)?
( ) Have you ever had abnormal bleeding associated with previous extractions, surgery or accidents?

DO YOU HAVE OR USE ANY OF THE FOLLOWING (INDICATE WITH X)

YES
( ) Teeth sensitive to cold, heat sweets or pressure
( ) Bleeding Gums; How Long ____________
( ) Food Impaction
( ) Unpleasant taste
( ) Bad breath
( ) Clenching or grinding of teeth

YES
( ) Frequent blisters on lips or mouth (cold sores)
( ) Swelling or lumps in mouth
( ) Pain around ear
( ) Headaches
( ) Orthodontic treatment
( ) Periodontial treatment (gums)

YES
( ) Oral habits (fingernail / check biting)
( ) Cigarette, pipe or cigar smoking
( ) Unfavorable dental experience
( ) Jaw clicking / popping
( ) TMJ / Jaw problems

MEDICAL HISTORY

PHYSICIAN'S NAME:	CITY:	DATE OF LAST PHYSICAL EXAM:

YES
( ) Has there been any recent change in your general health?
( ) Do you take any medications, drugs or pills (including birth control pills)? If yes, please list: ____
( ) Are you being treated for any condition by a physician now? If yes, please explain: ____
( ) Have you been hospitalized during the past two years? If yes, please explain: ____
( ) **ARE THERE ANY MEDICATIONS THAT YOU CANNOT TAKE OR ARE ALLERGIC TO OR HAVE HAD A REACTION TO?**
( ) PENICILLIN ( ) CODEINE ( ) NOVACAINE ( ) ASPIRIN ( ) ANESTHETICS ( ) LATEX ( ) OTHER __________________
( ) Have you ever had a General Anesthetic? List any problems: ____
( ) FOR WOMEN: Are you pregnant? If so, how many months? _________ months Are you breast feeding? ( ) Yes ( ) No

INDICATE WITH (X) ONLY IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

YES
( ) Rheumatic Fever
( ) Heart Murmur
( ) Heart Attack
( ) Cardiac Pacemaker
( ) Artificial Heart Valve
( ) Congenital Heart Disease
( ) Mitral Valve Prolapse
( ) Angina / Chest Pain
( ) High / Low Blood Pressure
( ) Stroke
( ) Ankle Swelling
( ) Tire Very Easily
( ) Fainting Spells
( ) Sinus Trouble

YES
( ) Shortness of Breath
( ) Sickle Cell Trait or Anemia
( ) Bleeding Disorder
( ) Diabetes
( ) Liver Disease
( ) Dialysis
( ) Hepatitis __________
( ) Tuberculosis
( ) Venereal Disease
( ) AIDS (HIV)
( ) Ulcers or Colitis
( ) Epilepsy or Seizures
( ) Long Disease
( ) Thyroid

YES
( ) Eye Disorders
( ) Muscular Disease
( ) Head / Spinal Injury
( ) Artificial Joint
( ) Organ Transplant
( ) Hormone Disorder
( ) Genetic Disorder
( ) Steroid Use
( ) Radiation Therapy
( ) Cancer Therapy
( ) Hayfever
( ) Asthma
( ) Arthritis
( ) Other ______________________

YES NO
( ) ( ) Is there any health information which was not asked which may influence dental treatment? If yes, please explain ______________

TO THE BEST OF MY KNOWLEDGE THE FOREGOING QUESTIONS HAVE BEEN ACCURATELY ANSWERED.

____ SIGNATURE OF PATIENT / PARENT

______________________________ REVIEWED BY D.D.S.

Note: Any change in your health status should be reported to this office at the earliest possible time.

PERMISSION TO RELEASE HEALTH INFORMATION: I grant the right to the dentist to release health information about me and information about my dental treatment to third party payors and / or other health practitioners.

____ SIGNATURE OF PERSON COMPLETING THIS FORM

______________ DATE

___________________________________ IF OTHER THAN PATIENT, INDICATE RELATIONSHIP