Curtis L. Barmby, DDS - Gail E. Frick, DMD

We are committed to providing the highest quality dental care for you in a manner that empowers you to have ongoing health throughout your life.

PATIENT INFORMATION

Date _____

1) Name _____ Preferred Name _____

Address _____ Birthdate _____

city _____ state _____ zip _____ Age _____ ☐ Male ☐ Female

Hm Phone ( ) _____ Soc. Sec. # _____

Wk Phone ( ) _____ Ext. _____ Driver's Lic. _____

Cell Phone ( ) _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

FAX ( ) _____ E-Mail _____

Full Time Student? ☐ YES ☐ NO School Name? _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY / INSURANCE INFORMATION

2) Name _____ Relationship to patient _____

Residence if different from patient's _____ Birthdate _____

city _____ state _____ zip _____ Soc. Sec. # _____

Hm Phone ( ) _____

Employer _____ Wk Phone ( ) _____ Ext. _____

Address street _____ city _____ state _____ zip _____

Primary Insurance _____ Group # _____

Insurance Co. Address _____ Phone # _____

3) Spouse _____ Relationship to patient _____

Wk Phone ( ) _____ Ext. _____ Birthdate _____

Employer _____ Soc. Sec. # _____

Address street _____ city _____ state _____ zip _____

Secondary Insurance _____ Group # _____

Insurance Co. Address _____ Phone # _____

EMERGENCY CONTACT

Whom may we notify in case of emergency?

4) Name _____

Hm Phone ( ) _____

Wk Phone ( ) _____ Ext. _____

Please Complete Both Sides

Health and Dental Information

Previous Dentist: _____ Phone: _____

Date of last dental exam: _____ Last full mouth X-rays: _____

Have you had trouble with any of the following?

Y / N Bad Breath
Y / N Bleeding Gums
Y / N Clicking or Popping Jaw
Y / N Food collection between teeth
Y / N Grinding Teeth
Y / N Loose Teeth or Broken Fillings
Y / N Periodontal Treatment
Y / N Sores or growths in your mouth
Y / N Sensitivity to Heat
Y / N Sensitivity to Cold
Y / N Sensitivity to Sweets
Y / N Sensitivity when Biting

Have you ever had any of the following?

Y / N AIDS / HIV Positive
Y / N Anemia
Y / N Aredia (chemotherapy)
Y / N Arthritis
Y / N Artificial Heart Valve
Y / N Artificial Joints
Y / N Asthma
Y / N Cancer or Tumors
Y / N Circulatory Problems
Y / N Diabetes
Y / N Dizziness or Fainting
Y / N Drug/Alcohol Addiction
Y / N Endocarditis (infection)
Y / N Epilepsy
Y / N Fen-Phen (Diet drug)
Y / N Headaches
Y / N Heart Disease
Explain _____
Y / N Heart Murmur
Y / N Hemophilia
Y / N Hepatitis A or B
Y / N High Blood Pressure
Y / N Jaw Pain
Y / N Kidney Disease
Y / N Liver Disease
Y / N Mental Disorders
Y / N Mitral Valve Prolapse
Y / N Pacemaker
Y / N Radiation Treatment
Y / N Respiratory Problems
Y / N Rheumatic Fever
Y / N Scarlet Fever
Y / N Sinus Problems
Y / N Stomach Problems
Y / N Stroke
Y / N Thyroid Problems
Y / N Tobacco Habit
Y / N Tuberculosis
Y / N Ulcers
Y / N Venereal Disease
Y / N Zometa (chemotherapy)

ALLERGIES

Y / N Latex
Y / N Penicillin Allergy
Y / N Erythromycin Allergy
Y / N Codeine Allergy
Y / N Aspirin Allergy
Y / N Other Drugs
Y / N _____
Y / N _____
Y / N _____
Y / N **Are you Pregnant?**
Due date: _____

- Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you require pre-medication prior to dental treatment? ☐ Yes ☐ No
- Please list any medications currently being taken: _____

_____

- Have you ever had any complications following dental treatment or local anesthetic? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____

Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any changes in my health status should occur.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance **CLEARLY** understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

_____ Date: _____
Signature of provider

(Revised 7/14/05)