PATIENT FORMS

Patients new to Goldberg Dentistry can save time by completing this Health History and the Release and bringing the completed forms with them on their first visit.

HEALTH HISTORY

Name _____ Date _____

Home Address _____

City _____ State _____ Zip Code _____

Date of Birth: _____

Telephone: Home _____ Work _____ Cell _____

Email Address: _____

DENTAL INSURANCE

Primary Insurance

Name of Subscriber/Insured _____ Date of Birth _____

Soc. Sec. # _____

Employer _____

Insurance Company _____

Group # _____ ID # _____

Secondary Insurance

Name of Subscriber/Insured _____ Date of Birth _____

Soc. Sec. # _____

Employer _____

Insurance Company _____

Group # _____ ID # _____

MEDICAL HISTORY

From the list below, check any of these which you have had or currently have

- ☐ AIDS or HIV+
- ☐ Allergies
- ☐ Artifical Valve or Joint
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bruise Easily
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Glaucoma
- ☐ Head/Neck Surgery
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hypertension
- ☐ IV Bisphosphonate
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus Trouble
- ☐ Stomach Disorder
- ☐ Venereal Disease

If female, are you pregnant? ◯ Yes ◯ No Taking birth control? ◯ Yes ◯ No

Note: There are drugs and medications used in some dental care that may decrease the effectiveness of your birth control. Patients taking birth control must utilize an additional method of contraception when using antibiotics.

Please list all medication you are taking: _____

_____

_____

Are you allergic to any of the following? Please check all that apply.

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Erythromycin
- ☐ Keflex
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Percodan
- ☐ Valium
- ☐ Other: _____

_____

Do you smoke? ◯ Yes ◯ No If yes, how much per day ? _____

DENTAL HISTORY

When was your last visit with a dentist? _____

When was the last time you had dental x-rays taken? _____

Are you happy with the appearance of your teeth? ◯ Yes ◯ No

Are you having any problems with your teeth, gums or facial muscles? ◯ Yes ◯ No

If yes, please describe. _____

_____

Do you have any complications associated with dental treatment? ◯ Yes ◯ No

If yes, please describe. _____

_____

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Do not write below this line.

Dentist review of history and significant findings: Signature _____ Date _____

Health History Update

I, _____, have reviewed this document and acknowledge that all the above information is current and up to date. Signature _____ Date _____

I, _____, have reviewed this document and acknowledge that all the above information is current and up to date. Signature _____ Date _____

RELEASE

Please read the following release and sign below.

It has been explained to me that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves, which cannot be determined prior to the administration of the anesthetic agent. Although risks seldom occur, they may include loss of or disturbed sensation to the tongue and lip on the injected site. If this occurs, it is often temporary and normal sensation usually returns in several days. In very rare cases, the loss of sensation may be prolonged or permanent. Injecting a foreign substance into the body (i.e. an anesthetic) may result in an allergic reaction. These reactions are rare. Unusual reactions to treatment cannot be predicted. If I experience any unanticipated reactions following the injection, I agree to report them to the office as soon as possible.

The success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status. I acknowledge that no guarantees or assurances can be given by anyone as to the results that may be obtained.

To the best of my knowledge, the information supplied is correct. The information will be held in strict confidence. I grant the dentist the right to release the information obtained from me, as well as treatment information, to the third party payers and/or health care practitioners.

I authorize the dental staff to perform any necessary dental services with informed consent. I am responsible for any charges incurred for dental treatment, regardless of dental insurance. I will be responsible for 1/5% interest per month on aging unpaid balances, for any attorney fees incurred to collect these balances and for any bank charges for returned checks.

Name_____

Signature_____ Date _____

If the signature is not that of the patient, what is your relationship? _____