COGBURN, TEAGUE, VAN PRAAG, D.D.S., P.A.

PATIENT HISTORY & INFORMATION SHEETS

WELCOME! WE ARE GLAD YOU ARE HERE. WE SINCERELY APPRECIATE YOU CHOOSING OUR OFFICE FOR YOUR DENTAL CARE. OUR GOAL IS TO PROVIDE YOU WITH THE BEST DENTAL CARE POSSIBLE IN A RELAXED AND CARING ATMOSPHERE. WE ARE HERE TO SERVE YOU AND WE THANK YOU FOR THAT OPPORTUNITY.

DATE_____________________________

NAME________________________________ Mailing Address________________________________

CITY______________________STATE___________ZIP_______________HM PHONE_______________

WORK PHONE_______________________CELL PHONE_____________________SEX (M/F)__________

MARITAL STATUS__________PATIENT BIRTHDAY______________SSN#___________________________

IN CASE OF EMERGENCY, NOTIFY____

PHONE NUMBER______________________

RESPONSIBLE PARTY NAME____

ADDRESS____

REFERRED BY____

IF YOU HAVE DENTAL INSURANCE:

DENTAL
INSURANCE Y/N________ EMPLOYER NAME____

INSURED NAME__________________________________SSN________________________

INSURED BIRTHDATE___________________________

INSURANCE COMPANY NAME______________________________GROUP#___________________________

INSURNACE CO. MAILING ADDRESS____

CITY________________________STATE________________________ZIP CODE________________________

DENTAL HISTORY

1. WHY HAVE YOU COME TO THE DENTIST TODAY?___________________________________

2. APPROXIMATELY WHEN WAS YOUR LAST DENTAL VISIT?______________________________

3. DO YOU CURRENTLY HAVE ANY TEETH THAT ARE SENSITIVE OR HURTING?______________

4. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? __________________________

   IF NOT, WHAT SPECIFICALLY, WOULD YOU LIKE TO CHANGE?___________________________

5. HAVE YOU EVER WISHED YOUR TEETH WERE WHITER? HAVE YOU CONSIDERED OR TRIED BLEACHING IN THE PAST?____

6. HAVE YOU SEEN DENTAL SPECIALISTS IN THE PAST? PERIODONTISTS, ENDODONTISTS OR ORTHODONTISTS?____

7. ARE YOU NERVOUS OR ANXIOUS ABOUT DENTAL TREATMENT? IF SO, IS THERE ANYTHING IN PARTICULAR THAT IS MOST CONCERNING?____

8. ARE THERE ANY OTHER DENTAL CONCERNS THAT YOU WOULD LIKE FOR US TO BE AWARE OF____

MEDICAL HISTORY

PLEASE LIST THE MEDICINES YOU ARE TAKING, INCLUDING OVER THE COUNTER MEDICINES____

PHYSICIAN NAME AND PHONE NUMBER____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY MEDICINES, DENTAL ANESTHETICS OR LATEX? PLEASE LIST____

DO YOU SMOKE,DIP,CHEW OR USE ANY FORM OR SMOKELESS TOBACCO?___________________

HAVE YOU BEEN TOLD BY A PHYSICIAN THAT YOU NEED PREMEDICATION FOR HEART PROBLEMS OR JOINT REPLACEMENT?____

HAVE YOU EVER HAD HIP, KNEE, SHOULDER OR BACK SURGERY?____________________________

HAVE YOU HAD ANY MAJOR SURGERIES?____

WOMEN: ARE YOU PREGNANT?____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOU:

MITRAL VALVE PROLAPSE HEART MURMUR RHEUMATIC FEVER STROKE

HEART SURGERY HEART ATTACK HIGH BLOOD PRESSURE HEMOPHILLIA

HEPATITIS HIV/AIDS DRUG/ALCOHOL ABUSE CANCER

DIABETES TUBERCULOSIS EPILEPSY SEIZURES CHEMOTHERAPY

KIDNEY DISEASE PHSYCHIATRIC DISORD SINUS PROBLEMS THRYOID DESEASE

TO OUR PATIENTS WITH DENTAL INSURANCE

DENTAL INSURANCE CARRIERS SET THEIR OWN "USUAL, CUSTOMARY, AND REASONABLE" REIMBURSEMENT FEES, BASED ON MAXIMIZING THEIR PROFITS AND MINIMIZING OUR DENTAL CARE. IN MOST CASES, THE CHARGES AT THIS OFFICE WILL EXCEDE, SOMETHIMES SIGNIFICANTLY, THE "UCR" FEE SCHEDULE SET BY YOUR INSURANCE COMPANY. BY SIGING BELOW, I ACKNOWLEDGE THIS AND PERMIT MY SIGNATURE TO SERVE AS AUTHORIZATION IN FILING MY INSURANCE FOR ME AND MY DEPENDENTS. I ALSO AGREEE TO HAVE PAYMENTS FROM MY INSURANCE COMPANY SENT DIRECTLY TO THIS OFFICE FOR REIMBURSEMENT OF THE ACTUAL CHARGES FOR MY DENTAL TREATMENT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR UNDERSTANDING MY INSURANCE COVERAGE AND THAT I PERSONALLY, NOT MY INSURANCE COMPANY, AM RESPONSIBLE FOR THE SERVICES AND CHARGES RENDERED ON MY BEHALF.

TO ALL PATIENTS

I UNDERSTAND THAT THE INFORMATION GIVEN TODAY IS CORRECT AND WILL BE HELD IN THE STRICTEST CONFIDENCE BY THIS OFFICE. PAYMENT IN FULL IS DUE AT THE TIME OF TREATMENT UNLES PRIOR ARRANGEMENTS HAVE BEEN APPROVED. WE ACCEPT CASH, PERSONAL CHECKS, MASTERCARD,VISA AND CARE CREDIT.

SIGNATURE_______________________________________DATE________________________________