Robert L. Coe, D.D.S., INC.

Welcome! We are pleased that you have chosen us to care for your dental health. Please help us by taking a minute to fill out **both** sides of this form. By law, all of your information will remain confidential.

# Patient History & Information

Patient Name_____________________________________________ Birthdate _________ Age ________M _____F_____ Nickname__________

Address (Home) ___________________________________________ Driver License __________________________ Marital Status ___________

City __________________________________ Zip ______________ Phone (Home) _______________ Phone (Cell) ______________________

E-mail Address ______________________________________ Social Security # ________________________________________________

Employer _______________________________________________ Phone (Business) _______________________________________________

Address ________________________________________________ City _____________________________________ Zip_________________

## MEDICAL HISTORY

Primary Physician's Name ________________________________________________ Phone _____________________________________________

Address _________________________________________ Date of Last Physical Exam __________________________________________

Have you been under a medical doctor's care or hospitalized within the past 5 years? __________________________________________________

Are you presently taking any medications? ❑Yes ❑No If yes, please list them: _____________________________________________________

Do you need to take premedication for dental treatment? ❑Yes ❑No If yes, what medication and dosage? ________________________________

Are you allergic to: Penicillin ❑ Codeine ❑ Novocaine ❑ Latex ❑ Other ❑ (please specify) ___________________________________

Do you smoke? ❑Yes ❑No Are you pregnant? ❑Yes ❑No Are you nursing? ❑Yes ❑No Blood Pressure: S_______ D _____________

Have you ever had any excessive bleeding requiring special treatment? ❑Yes ❑No

Please list any serious medical conditions(s) you have ever had: ______________________________________________________________________

Have you ever had any of the following diseases or medical problems?

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart Problems | ❑ | ❑ | Excessive Bleeding | ❑ | ❑ | Malignancies | ❑ | ❑ | Anemia | ❑ | ❑ |
| Heart Murmur | ❑ | ❑ | Rheumatic Fever | ❑ | ❑ | Yellow Jaundice | ❑ | ❑ | Stroke | ❑ | ❑ |
| Artificial Joint | ❑ | ❑ | Epilepsy/Seizures | ❑ | ❑ | HIV/Aids | ❑ | ❑ | Hepatitis | ❑ | ❑ |
| Diabetes | ❑ | ❑ | Abnormal Blood Pressure | ❑ | ❑ | Substance Abuse | ❑ | ❑ | Cancer | ❑ | ❑ |
| Artificial Valve | ❑ | ❑ | Tuberculosis | ❑ | ❑ | Asthma | ❑ | ❑ | Fainting | ❑ | ❑ |
| Psychiatric Care | ❑ | ❑ | Sinus Problems | ❑ | ❑ | Venereal Disease | ❑ | ❑ | | | |

## DENTAL HISTORY

Former Dentist's Name _______________________________________________________________ Phone ___________________________________

Date of Last Visit ___________________________________ What was done at that time? ________________________________________________

Did you have X-Rays taken? ❑Yes ❑No Do you have any missing teeth? ____________________

What concerns you most regarding your dental needs? _______________________________________________________________________________

Are you having any discomfort at this time? ____________________ What is the discomfort? ____________________________________________

Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

Have you ever had braces? ❑Yes ❑No Do you ever hear clicking or popping noises in your jaw? ❑Yes ❑No

Do you have trouble opening or closing your mouth? ❑Yes ❑No Are there old fillings or dental work that you don't like looking at? ❑Yes ❑No

Are your teeth sensitive to heat, cold, sweets or biting pressure? ❑Yes ❑No Does food get trapped in your teeth? ❑Yes ❑No

Who may we thank for referring you to our office? __________________________________________________________

**To the best of my knowledge, all of the answers are true and correct. If I ever have any change in my health status, or any medication changes, I will inform the dentist at the next appointment. The undersigned understands that they are responsible for the payment of charges incurred for all services rendered and gives their permission for all necessary and approved treatment rendered.**

**Patient's Signature:** ____________________________**Date**___________ **Doctor's Signature**________________________________**Date**_________

# FINANCIAL & INSURANCE INFORMATION

## Spouse or Parent Information

Name ____________________________________________________ Relationship_____________ Social Security #___________________________

Address __________________________________________________ Driver License # ____________________________________________________

Employer _________________________________________________ Birthdate ___________________ Business Phone # _____________________

## Insurance Information: If card or form only provided, check here ___________ No Insurance, check here ______________

**Primary Dental Insurance Company**__________________________________________________________________________________________

Address______________________________________________________________City/State/Zip____________________________________________

Insurance Phone______________________________________________________________________________________________________________

Employer Name ___________________________________________________ Group Name_______________________________________

Subscriber Name _________________________________________________ Subscriber ID/SSN__________________________________

Subscriber Date of Birth_________________________________________ Relationship___________ Policy Number______________

**Secondary Dental Insurance Company**________________________________________________________________________________________

Address__________________________________________________City/State/Zip_______________________________________________________

Insurance Phone______________________________________________________________________________________________________________

Employer Name____________________________________________________ Group Name_______________________________________

Subscriber Name__________________________________________________ Subscriber ID/SSN__________________________________

Subscriber Date of Birth_________________________________________ Relationship _________ Policy Number_______________

**<u>Authorization to Release Information</u>: I authorize my dentist to release any information or x-rays to my insurance company or to any necessary specialists I may need to see for any oral or dental observation, treatment, services or benefits rendered or payable to me or in my behalf or in behalf of my eligible dependents.**

**Signature** ______________________________________________________________________ **Date** _______________________________________

(Signature of Patient or Parent/Guardian)

**<u>AUTHORIZATION TO PAY BENEFITS TO DENTIST</u>: I authorize payment directly to Dr. Coe otherwise payable to me.**

**Signature** ______________________________________________________________________ **Date** _______________________________________

(Signature of Patient or Parent/Guardian)