DATE _____ BIRTHDATE _____

NAME _____

SSN _____

PRECISION Dental GROUP

1315 Ridge Road, Hinckley OH 44233
330.278.1061 hinckleyprecisiondental.com

ABOUT YOU

ADDRESS _____ HOME PHONE _____

CITY _____ ZIP _____ CELL PHONE _____

☐MALE ☐FEMALE | ☐MINOR ☐SINGLE ☐MARRIED ☐DIVORCED | EMAIL _____

EMPLOYER _____ BUS. PHONE _____

ADDRESS _____ OCCUPATION _____

EMERGENCY CONTACT _____ PHONE _____

WHOM SHOULD WE THANK FOR REFERRING YOU (please check all that apply) ☐ Richfield Times ☐ Hinckley Record ☐ Brunswick Life

☐ Direct Mail/Flyer ☐ Network Referral ☐ Patient | Name _____ ☐ Other | Explain _____

PRIMARY DENTAL INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____

RELATIONSHIP TO PATIENT _____ BIRTH DATE _____ SSN _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____

RESPONSIBLE PARTY EMPLOYER _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ OCCUPATION _____

INSURANCE COMPANY _____ SUBSCRIBER ID# _____

INSURANCE COMPANY ADDRESS _____ GROUP # _____

ADDITIONAL INSURANCE

INSURED NAME _____

RELATIONSHIP TO PATIENT _____ BIRTH DATE _____ SSN _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____

INSURED EMPLOYER _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ OCCUPATION _____

INSURANCE COMPANY _____ SUBSCRIBER ID# _____

INSURANCE COMPANY ADDRESS _____ GROUP # _____

DENTAL HISTORY

FORMER DENTIST _____ DATE OF LAST X-RAYS _____

CITY/STATE _____ HOW OFTEN YOU FLOSS _____

DATE OF LAST DENTAL VISIT _____ HOW OFTEN YOU BRUSH _____

PLEASE CHECK ALL THAT APPLY:

- ☐ BAD BREATH
- ☐ BLEEDING GUMS
- ☐ BLISTERS ON LIPS OR MOUTH
- ☐ FREQUENT HEADACHES
- ☐ GRINDING TEETH
- ☐ JAW-HEAD-NECK INJURIES
- ☐ JAW CLICKING OR PAIN
- ☐ LIP OR CHEEK BITING
- ☐ LOOSE TEETH/BROKEN FILLINGS
- ☐ NAIL BITING
- ☐ ORTHODONTICS
- ☐ PAIN AROUND EAR
- ☐ PERIODONTAL TREATMENT
- ☐ SENSITIVITY TO COLD
- ☐ SENSITIVITY TO HEAT
- ☐ SENSITIVITY TO SWEETS
- ☐ SENSITIVITY WHEN BITING
- ☐ TOOTH PAIN

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE LAST VISITED _____

1. CURRENTLY UNDER MEDICAL TREATMENT? ☐ YES ☐ NO
2. ANY SERIOUS ILLNESSES OR OPERATIONS? ☐ YES ☐ NO
   IF YES, PLEASE DESCRIBE _____
   _____
   _____
3. CURRENTLY TAKING MEDICATIONS? ☐ YES ☐ NO
   IF YES, PLEASE DESCRIBE _____
   _____
   _____
4. USE TOBACCO ☐ YES ☐ NO
5. USE ALCOHOL? ☐ YES ☐ NO
6. USE COCAINE OR OTHER DRUGS? ☐ YES ☐ NO
7. WEAR CONTACT LENSES? ☐ YES ☐ NO
8. ANY ALLERGIC REACTIONS TO:
   - LOCAL ANESTHETICS ☐ YES ☐ NO
   - PENICILLIN OR OTHER ANTIBIOTICS ☐ YES ☐ NO
   - SULFA DRUGS ☐ YES ☐ NO
   - BARBITURATES (SLEEPING PILLS) ☐ YES ☐ NO
   - SEDATIVES ☐ YES ☐ NO
   - IODINE ☐ YES ☐ NO
   - ASPIRIN ☐ YES ☐ NO
   - OTHER ☐ YES ☐ NO
   - PLEASE EXPLAIN _____
9. (WOMEN ONLY) ARE YOU:
   - PREGNANT ☐ YES ☐ NO
   - NURSING ☐ YES ☐ NO
   - TAKING CONTRACEPTIVES ☐ YES ☐ NO

PLEASE CHECK ALL THAT APPLY:

- ☐ AIDS
- ☐ ANEMIA
- ☐ ARTHRITIS, RHEUMATISM
- ☐ ARTIFICAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BACK PROBLEMS
- ☐ BLEEDING ABNORMALLY W/EXTRACTION/SURGERY
- ☐ BLOOD DISEASE
- ☐ CANCER
- ☐ CHEMICAL DEPENDENCY
- ☐ CHEMOTHERAPY
- ☐ CHRONIC FATIGUE SYNDROME
- ☐ CIRCULATORY PROBLEMS
- ☐ CONGENITAL HEART LESIONS
- ☐ CORTISONE TREATMENTS
- ☐ COUGH – PERSISTENT OR BLOODY
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ EPILEPSY
- ☐ FAINTING/DIZZINESS
- ☐ GLAUCOMA
- ☐ HEADACHES
- ☐ HEART MURMUR
- ☐ HEART PROBLEMS
- ☐ HEPATITIS TYPE ____
- ☐ HERPES
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV POSITIVE
- ☐ JAUNDICE
- ☐ JAW PAIN
- ☐ LATEX SENSITIVITY
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ MITRAL VALVE PROLAPSE
- ☐ NERVOUS PROBLEMS
- ☐ PACEMAKER
- ☐ PSYCHIATRIC CARE
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SHORTNESS OF BREATH
- ☐ SINUS TROUBLE
- ☐ SKIN RASH
- ☐ STROKE
- ☐ SWELLING OF FEET OR ANKLES
- ☐ SWOLLEN NECK GLANDS
- ☐ THYROID PROBLEMS
- ☐ TONSILITIS
- ☐ TUBERCULOSIS
- ☐ TUMOR/GROWTH ON HEAD OR NECK
- ☐ ULCER
- ☐ VENEREAL DISEASE

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Precision Dental Group for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance, and for all services rendered on my behalf or my dependents'.

I authorize the doctors, providers or suppliers of Precision Dental Group to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____