Rick Blaich, D.M.D.
John Blaich, D.M.D.
Eric Blaich, D.D.S.
Travis Blaich, D.D.S.
Lauren Blaich, D.D.S.

Dental Arts Group

PATIENT INFORMATION

Date ________________

PATIENT NAME: ______________________ Age______ Birthdate__________ Sex_____
Address ______________________ City__________ State______ Zip________
Home Phone ______________ Work Phone__________ Cell Phone__________
Email______________________ Single_____ Married_____ Widowed_____ Divorced_____
Social Security No. ____________ Full time Student?______ Name of School______________
Employed by ____
We're happy you chose our dental practice. How did you find out about us? ______________________
____

ACCOUNT TO BE PAID BY: (SIGNATURE OF PERSON PAYING ACCOUNT IS REQUIRED BELOW)
Mr., Mrs., Ms., Other__________ Home Phone #______________
Name ______________________ Birthdate__________ Relationship to patient______________
Home Address______________________ City__________ State______ Zip________
Employed by ______________________ Occupation______________________
Address ______________________ City__________ State______ Zip________
Work Phone ______________ Ext.__________ Are calls allowed?__________
Social Security No. ______________ Single_____ Married_____ Widowed_____ Divorced_____
Dental Insurance Co.____

PLEASE PRESENT YOUR INSURANCE CARD

SPOUSE OF RESPONSIBLE PARTY INFORMATION:
Name______________________ Relationship to Patient __________ Birthdate________
Employed by ______________________ Occupation______________________
Address ______________________ City__________ State______ Zip________
Work Phone __________ Ext.________ Are calls allowed?________ Soc. Security No.__________
Dental Insurance Co.______________________ Phone No.______________________
Address ______________________ City__________ State______ Zip________
Person to contact in case of an emergency, other than person in the home ______________________
____

HEALTH INFORMATION:
Name of Family Physician ______________________ Phone #______________

Circle any of the following conditions which you have now or may have had in the past:

Heart Problems	Excessive Bleeding	Cold Sores	Nervous Problems
High Blood Pressure	Hemophilia	Tuberculosis	Fainting/Dizzy Spells
Circulatory Problems	Epilepsy/Seizures	Malignancies	Pain in Jaw Joints
Heart Murmur	Kidney Problems	Radiation Treatment	Sexually Transmitted Diseases
Rheumatic Fever	Liver Disease	Asthma	Cancer Treatment
Mitral Valve Prolapse	Hepatitis	Cortisone Therapy	Bone Supplement Therapy
Artificial Joint	Aids/or HIV Infection	Diabetes	
Anemia	Stomach Ulcers/Bleeding		

Other conditions not listed above ____
____

PLEASE TURN OVER

PATIENT DENTAL HISTORY:

Name of previous dentist and location________________________ Date of last exam______________

Question	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sour or sweet liquids/foods?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you ever experienced any of the following problems with your jaw?		
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding following extractions?	❑	❑
13. Have you had any orthodontic treatment?	❑	❑
14. Do you wear dentures or partials?	❑	❑
If yes, date of placement______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑
16. Do you like your smile?	❑	❑

PATIENT HEALTH HISTORY:

1. Are you allergic to or have you had any reactions to the following?

Question	Yes	No
Local Anesthetics (e.g. novocaine)	❑	❑
Penicillin	❑	❑
Other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (please list)______________	❑	❑
2. Are you under medical treatment now?	❑	❑
3. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑

If yes, please explain______________________________

____

Question	Yes	No
4. Are you taking any medication(s) including non-prescription medicine?	❑	❑

If yes, what medication(s) are you taking______________________________

____

____

____

Question	Yes	No
5. Do you use tobacco?	❑	❑
6. Do you use controlled substances?	❑	❑
7. Are you wearing contact lenses?	❑	❑
8. Has your physician advised you to be pre-medicated before dental work?	❑	❑
9. Do you take any blood thinners?	❑	❑
10. Do you have any artificial joints?	❑	❑
11. Women Only:		
a) Are you pregnant or think you might be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

Authorization and Release / HIPPA

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If my account balance is sent to an outside agency for collection, I am responsible for collection fees Dental Arts must pay to said agency. I authorize Dr. Rick Blaich, Dr. John Blaich and/or Dr. Eric Blaich to perform any treatment, medication and therapy that may be indicated in connection with my dental care or the dental care of the minor child listed above. I understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or staff.

X ____

Signature of patient and/or responsible party — Date

Thank you for selecting our Dental Healthcare Team. If you have any questions, please ask us. We will be happy to help.