# Dr. Jerry L. Rinehart DDS

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The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. The better we communicate, the better we can care for you.

## ABOUT YOU

Name: ______________________________ Today's Date: ____________
Last First Mi

I prefer to be called: ______________ Birth Date: ________ Age: ______ ☐Male ☐Female

Email address: ______________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home address: ______________________________
Apt/Condo # City State Zip

Home Phone: ____________ Work Phone: __________ ext: ___ Cell Phone ________

Employer: ____________ Employer Address: __________ How long there? ______

Occupation: ____________ Where and when are best times to reach you? __________

Whom may we thank for referring you? __________ Previous/Present Dentist: __________

Last Visit Date: ____________ Other family members seen by us: ______________

## SPOUSE INFORMATION

His/Her Name: ______________ SS#: __________ Birth Date: ____ ________

Employer: ____________ Work Phone: ______________ ext: ______

Person Responsible for Account ____________ Work Phone: __________ ext: ______

Home Phone: ______________ Billing Address: ______________

SS# ______________ Employer: ______________

## PRIMARY INSURANCE

Dental Coverage ☐ Yes ☐ No

Insurance Co. Name: __________ Ins. Co. Address: ______________

Ins. Co. Phone: ____________ Group # (Plan, Local or Policy #) ______________

Insured's Name: ____________ Relation: ________ Insured's Birth Date: __________

Insured's ID #: ____________ Insured's employer: ______ Employer Address: ______

## SECONDARY INSURANCE

Dental Coverage ☐ Yes ☐ No

Insurance Co. Name: __________ Ins. Co. Address: ______________

Ins. Co. Phone: ____________ Group # (Plan, Local or Policy #) ______________

Insured's Name: ____________ Relation: ________ Insured's Birth Date: __________

Insured's ID #: ____________ Insured's employer: ______ Employer Address: ______

## MEDICAL HISTORY

YOUR CURRENT PHYSICAL HEALTH IS: ☐Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: ________________________________________

____________________________________________________________

Have you ever taken Fosamax or any other Bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

FOR WOMEN: Are you taking a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _________________

Are you nursing? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS:

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Herpes/Fever Blisters |
| Y | N | Alcohol/Drug Abuse | Y | N | High Blood Pressure |
| Y | N | Anemia | Y | N | HIV+/AIDS |
| Y | N | Arthritis | Y | N | Hospitalized for any reason |
| Y | N | Artif. bones/joints/valves | Y | N | Kidney Problems |
| Y | N | Asthma | Y | N | Liver Disease |
| Y | N | Blood Transfusion | Y | N | Low Blood Pressure |
| Y | N | Cancer/Chemotherapy | Y | N | Lupus |
| Y | N | Colitis | Y | N | Mitral Valve Prolapse |
| Y | N | Congenital Heart Defect | Y | N | Osteoporosis/Paget's Disease |
| Y | N | Diabetes | Y | N | Pacemaker |
| Y | N | Difficulty Breathing | Y | N | Psychiatric Problems |
| Y | N | Emphysema | Y | N | Radiation Treatment |
| Y | N | Epilepsy | Y | N | Rheumatic/Scarlet Fever |
| Y | N | Fainting Spells | Y | N | Seizures |
| Y | N | Frequent Headaches | Y | N | Shingles |
| Y | N | Glaucoma | Y | N | Sickle Cell Disease/Traits |
| Y | N | Hay Fever | Y | N | Sinus Problems |
| Y | N | Heart Attack | Y | N | Stroke |
| Y | N | Heart Murmur | Y | N | Thyroid Problems |
| Y | N | Heart Surgery | Y | N | Tuberculosis (TB) |
| Y | N | Hemophilia | Y | N | Ulcers |
| Y | N | Hepatitis | Y | N | Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

____________________________________________________________

____________________________________________________________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | Aspirin | Y | N | Erythromycin | Y | N | Tetracycline |
| Y | N | Codeine | Y | N | Latex | Y | N | Other |
| Y | N | Penicillin | Y | N | Dental Anesthetics | | | |

Please list any other drugs/materials that you are allergic to:

____________________________________________________________

____________________________________________________________

## DENTAL HISTORY

WHY HAVE YOU COME TO THE DENTIST TODAY? ________________

____________________________________________________________

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had gum treatment: ☐ Yes ☐ No

DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN/ DISCOMFORT IN YOUR JAW JOINT (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? ________________________

How many times a day do you brush?_________________________

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it?__________

Are your teeth sensitive to heat, cold, or anything else? _________

Have you lost any teeth? ☐ Yes ☐ No If yes, why? ___________

____________________________________________________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____________________________________________________________

Signature Date

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT
Unless prior arrangements have been approved

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. If my account becomes seriously delinquent, I agree to pay the $75 charge associated with the collection fees.

____________________________________________________________

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.