Date:

Gerald R. Berg D.M.D.

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Patient Information…

Last Name: ____________________ **First Name:** ____________________ **M.I.** ________

Social Security Number: ____________________ **Date of Birth:** ____________________

Email: ____

Sex: ☐ *M* ☐ *F* ☐ *Married* ☐ *Separated* ☐ *Widowed* ☐ *Divorced* ☐ *Single* ☐ *Partnered* ☐ *Minor*

Spouses Name: ____________________ **How many children?** ________ **Age(s):** ________

Address: ____________________ **City:** ____________________ **State:** ________ **Zip:** ________

Cell Phone: ____________________ **Home Phone:** ____________________ **Work Phone:** ____________________

Employer Name: ____

Employer Address: ____

____

____

Person to contact in case of emergency: ____________________ **Phone Number:** ____________________

Responsible Person for this account: ____________________ **Relationship to Patient:** ____________________

Address, Phone numbers, Birthdate, Employer, Email, **(if different than above:)** ____________________

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____

Whom may we thank for referring you to our office? ____

Over ➡

Primary Dental Plan Information…

Employer: ________________________________ **Phone Number:** ________________

Dental Plan: ________________________________ **Phone Number:** ________________

Policy #: ________________________ **Group #:** ________________________

Dental Plan Address: ____

________________________ **State:** ________________ **Zip:** ________________

Name of Insured: ________________________ **Relationship to Patient:** ________________

Secondary Dental Plan Information…

Employer: ________________________________ **Phone Number:** ________________

Dental Plan: ________________________________ **Phone Number:** ________________

Policy #: ________________________ **Group #:** ________________________

Dental Plan Address: ____

________________________ **State:** ________________ **Zip:** ________________

Name of Insured: ________________________ **Relationship to Patient:** ________________

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my dental plan. I also accept responsibility for fees that exceed the payment made by dental plan(s). I agree to pay all co-payments and deductibles at the time the service is rendered. When your dental plans maximum yearly amount is reached you will be responsible for the treatments that exceed that limit.

Signature of patient or guardian: ________________________ **Date:** ________________

Over

Dental History…

Reason for today's visit: ________ **Date of last dental visit?** ________

Previous dentist: ________ **How often do you floss?** ________ **How often do you brush?** ________

Do you use tobacco? ☐ Yes ☐ No **How often?** ________ **How many years?** ________

Do you have or have had any of the following dental problems…?

☐ *Abscesses*	☐ *Clicking in joints*	☐ *Migraines*
☐ *Bad Breath*	☐ *Crowded teeth*	☐ *Pain in neck*
☐ *Bite not even*	☐ *Discolored teeth*	☐ *Sensitive to cold*
☐ *Bleeding gums*	☐ *Food collecting in between teeth*	☐ *Sensitive to hot*
☐ *Broken fillings*	☐ *Gum line decay*	☐ *Sensitive to sweet*
☐ *Broken teeth*	☐ *Grinding teeth*	☐ *Sores in mouth*
☐ *Broken crowns*	☐ *Headaches*	☐ *Sore muscles in mouth*
☐ *Chewing hard foods*	☐ *Loose teeth*	☐ *Other:*

☐ *Other Problems:* ________

Medical History…

Physician's Name: ________ **Phone number:** ________ **Last visit:** ________

Have you had any serious illnesses or operations: ☐ Yes ☐ No **Description?** ________

Are you taking blood thinners? ☐ Yes ☐ No ***Fosamax, Boniva, Aspirin?*** ☐ Yes ☐ No

Women…

Are you Pregnant? ☐ Yes ☐ No ***Nursing?*** ☐ Yes ☐ No ***Taking birth control pills?*** ☐ Yes ☐ No

Over

Medical History… *(Continued)*

Do you have or have had any of the following Medical problems…?

- ☐ *Anemia*
- ☐ *Arthritis, rheumatism*
- ☐ *Artificial heart valves*
- ☐ *Artificial joints*
- ☐ *Asthma*
- ☐ *Back problems*
- ☐ *Bleeding abnormalities*
- ☐ *Blood disease*
- ☐ *Cancer*
- ☐ *Chemotherapy*
- ☐ *Chemical dependency*
- ☐ *Circulatory problems*
- ☐ *Congenital heart lesions*
- ☐ *Cortisone treatments*
- ☐ *Cough, persistent*
- ☐ *Coughing up blood*
- ☐ *Diabetes*
- ☐ *Epilepsy*
- ☐ *Fainting*
- ☐ *Glaucoma*
- ☐ *Headaches*
- ☐ *Heart murmur*
- ☐ *Heart problems*
- ☐ *Hemophilia*
- ☐ *Hepatitis*
- ☐ *Hernia repair*
- ☐ *High blood pressures*
- ☐ *HIV/AIDS*
- ☐ *Kidney disease*
- ☐ *Liver disease*
- ☐ *Mitral valve prolapse*
- ☐ *Osteoporosis*
- ☐ *Pacemaker*
- ☐ *Respiratory disease*
- ☐ *Rheumatic fever*
- ☐ *Radiation treatment*
- ☐ *Scarlet fever*
- ☐ *Shortness of breath*
- ☐ *Skin rash*
- ☐ *Stroke*
- ☐ *Swelling feet/ ankles Back problems*
- ☐ *Thyroid problems*
- ☐ *Tobacco habit*
- ☐ *Tonsillitis*
- ☐ *Tuberculosis*
- ☐ *Ulcers*
- ☐ *Venereal disease*
- ☐ *Other:*

List current medications being taken: ______________________________

____

Allergies…

Do you have any Allergies…?

- ☐ *None*
- ☐ *Codeine*
- ☐ *Penicillin*
- ☐ *Sulfa*
- ☐ *Local Anesthetic*
- ☐ *Latex*
- ☐ *Iodine*
- ☐ *Epinephrine*
- ☐ *Other: Write below*

____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Berg, or his staff if any changes have occurred.

Signature of patient or guardian: ______________________ **Date:** ______________