Business/Cell Phone: Include area code _____

Soc. Sec. # _____

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	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 sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to 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 in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
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?	☐	☐

Authorization and Release

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 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.

X _____

Signature of patient (or parent if minor)

Bruce Mathes, D.D.S.

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken or plan to take Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No		
Do you use tobacco or any type?	◯ Yes ◯ No		
Do you use controlled substances(Drugs)?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Taking Birth Controll Pills or Hormonal Replacement ? ☐ Pregnant or Trying to get pregnant? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin	☐ Acrylic	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Penicillin or Other Anitibiotics	☐ Barbiturates, Sedatives or Sleeping Pills	☐ Codeine or Other Narcotics	☐ Metals
☐ Latex(Rubber)	☐ Hay Ferver or Seasonal	☐ Animals or Food	☐ Other

Do you have, or have you had, any of the following?

Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No	Anemia ◯ Yes ◯ No
Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No	Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No
Scarlet Fever ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No
Shingles ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No
Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No
Frequent Headaches ◯ Yes ◯ No	Stroke ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No
Tonsillitis ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No
Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Hepatitis A, B or C ◯ Yes ◯ No	Diabetes 1 or 11 ◯ Yes ◯ No	Artificial Joint Replacement (hip,knee or shoulder) ◯ Yes ◯ No	Low High Blood Pressure ◯ Yes ◯ No
AIDS or HIV Infection ◯ Yes ◯ No	Autoimmune Disease ◯ Yes ◯ No	Jaundice or Liver Disease ◯ Yes ◯ No	Chemotherapy or Radiation Treatments ◯ Yes ◯ No
Arthritis or Gout ◯ Yes ◯ No	Easily Winded or Breathing Problems ◯ Yes ◯ No	Heart Attack or Failure ◯ Yes ◯ No	Fainting Spells or Dizziness ◯ Yes ◯ No
Cold Sores or Fever Blisters ◯ Yes ◯ No	Mental Health Disorder ◯ Yes ◯ No	Asthma or Bronchitis ◯ Yes ◯ No	Stomach or Intestinal Disease ◯ Yes ◯ No
Gastrointestinal Disease or Reflux ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

AUTHORIZATION AND RELEASE

Adults age 18 and older :

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners. If I have insurance, I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree with or without insurance to be 100% responsible for payment of all services rendered on my behalf. If this account should become delinquent, the patient authorizes Dr.Bruce Mathes D.D.S to charge the patient's account with any past due finance charges, delinquent or legal fees which may be applicable. I agree that if my account becomes past due and is placed with an agency for collection purposes, I agree to pay all collection agency fees(which are typically 33-50%) , reasonable attorney's fees and court costs.

Signature of patient _____ **Date**_____

Minors under age 18:

I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third payers and/or other health practitioners. If I have insurance, I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less the actual bill for services. I agree with or without insurance to be 100% responsible for payment of all services rendered on my child's behalf. . If this account should become delinquent, the patient authorizes Dr.Bruce Mathes D.D.S to charge the patient's account with any past due finance charges, delinquent or legal fees which may be applicable. I agree that if my account becomes past due and is placed with an agency for collection purposes, I agree to pay all collection agency fees(which are typically 33-50%) , reasonable attorney's fees and court costs.

Signature of patient _____ **Date**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Dr.Bruce Mathes D.D.S

121 East Lake Avenue, Suite G

Peoria, IL 61614

(309) 685-2112

I hereby acknowledge that I have received a copy of this dental practice's Notice of Privacy Practices for my records.

Print name: _____

Relationship to patient:_____

Signature:_____**Date**_____

Person(S) Authorized to make Disclosure:_____.

Person(S) Authorized to Receive Disclosure:_____.

Yes / No (circle one) I would like to receive a copy of any amended Notice Of Privacy Practices by mail at: _____.

Or by email at: _____.

For office use only:

Signed form received by: _____

Acknowledgement refused: _____

Efforts to obtain: _____

Reason for refusal: _____