Gary G. Linn D.D.S., P.C.
Family Dental Care

PATIENT INFORMATION/HEALTH HISTORY

YOU

Name ________________________________ Preferred__________ Date__________ Social Security#______-_____-______
First *Last* *MI*

Address ______________________________ City______________ State _____ Zip_______

Date of Birth ___/___/___ Cell Phone______________ Work______________ Home ______________ *(circle preferred)*

❑ M ❑ F ❑ Married ❑ Single ❑ Minor ❑ Other Email______________________________

Employer ____

Emergency Contact (name & phone)______________________________ Relationship ______________

Referred by____

Reason for today's visit____

HEALTH HISTORY

Are you allergic to any medication? *(Please list)* ______________________________

Please list ALL medications you are currently taking ______________________________

____

____

Preferred Pharmacy ____

Are you taking any medications for bone density? *(Please list)* ______________________________

Please check any of the following that apply:

______AIDS/HIV
______ALCOHOL/DRUG ABUSE
______ANEMIA
______ANXIETY/DEPRESSION
______ARTHRITIS
______ARTIFICIAL JOINTS-Year: ________
______ASTHMA
______BLOOD DISEASE
______CANCER-Type: ______________
______CONGENITAL HEART DEFECT
______DIABETES
______DIZZINESS
______EMPHYSEMA
______EPILEPSY
______EXCESSIVE BLEEDING
______FAINTING
______FEVER BLISTERS
______GLAUCOMA
______HEAD INJURY
______HEART DISEASE
______HEART MURMUR
______HEPATITIS
______HIGH BLOOD PRESSURE
______KIDNEY DISEASE
______LATEX ALLERGIES
______LIVER DISEASE
______LUPUS
______LOW BLOOD PRESSURE
______MITRAL VALVE PROLAPSE
______OSTEOPOROSIS
______PACEMAKER
______RADIATION TREATMENT
______RESPIRATORY PROBLEMS
______RHEUMATIC FEVER
______SEASONAL ALLERGIES
______SEIZURES
______SEXUALLY TRANSMITTED DISEASES
______SINUS PROBLEMS
______STOMACH PROBLEMS
______STROKE
______THYROID PROBLEMS
______TMJ/TMD PROBLEMS
______TOBACCO HABITS
Type: ______________
How Long: ______________
______TONSILLITIS
______TUBERCULOSIS (TB)
______ULCERS

For Female Patients: Are you pregnant? ❑ Y ❑ N Week #______ Are you nursing? ❑ Y ❑ N

Please explain any **YES** answers to the above or any conditions not listed ______________________________

____

Name of Primary Physician______________________________ Phone #______________________

Have you been admitted to a hospital or needed emergency care during the past 2 years? ❑ Y ❑ N If **Yes** please explain ______________

____

DENTAL HISTORY

Have you had any complications following dental treatment in the past 2 years ❑ Y ❑ N If **Yes** please explain ______________________________

____

Are you currently in dental pain? ❑ Y ❑ N
Are you aware of any broken teeth or fillings? ❑ Y ❑ N
Have you had head neck or jaw injuries or pain? ❑ Y ❑ N
Have you ever had periodontal disease? ❑ Y ❑ N
Do you or any members of your family wear dentures? ❑ Y ❑ N
Do you require antibiotics before treatment? ❑ Y ❑ N
Do you have sores or lumps in or near your mouth? ❑ Y ❑ N
Do your gums ever bleed while brushing or flossing? ❑ Y ❑ N
Do you have mobility in your teeth? ❑ Y ❑ N
Would you like whiter teeth? ❑ Y ❑ N

SPOUSE OR RESPONSIBLE PARTY *(IF OTHER THAN YOURSELF)*

Name ______________________________ Relationship ______________________________
Last *First* *MI*

Date of Birth ____/____/____

Phone ______________________________ Social Security# ______-______-______

Billing Address ______________________________

DENTAL INSURANCE INFORMATION

Insured ______________________________ SS # ______-______-______

Insurance Company ______________________________ Phone ______________________________

Is Insured a Patient? ❑ Y ❑ N Insured's DOB ____/____/____ Relationship to the Insured ❑ Self ❑ Spouse ❑ Child ❑ Other ______________

ID# ______________________________ Group# ______________________________

Insured's Employer ______________________________

CONSENT FOR PAYMENT

In consideration for the professional services rendered to me during treatment I agree to pay on the date of service. If insurance will be filed for these procedures our office will assist in most insurance claims. I certify that I am covered by the dental insurance listed above. Insurance assignments shall be paid directly to Gary G. Linn DDS, PC. I understand that I am responsible for payment of services rendered and am also responsible for any co-payment and deductible amounts not covered by insurance. I hereby authorize Gary G. Linn, DDS, PC to release all information necessary to secure the payment of benefits and I authorize the use of this signature on all my insurance submissions. I am aware that any pre-authorized procedures or quotes given by our office and/or the insurance company are estimates ONLY. I understand that treatment plan fee estimates may only be extended for a period of 6 months from the date of examination. I grant my permission to the staff at Gary G. Linn D.D.S. P.C. to contact me by phone, email or text using the information provided on this form. This consent shall be considered in effect until rescinded or revoked.

______________________________ ______________
(Printed name – Patient, Parent or Guardian) (Date)

______________________________ ______________
(Signature) (Date)

CONSENT FOR SERVICES

I give consent for **myself / my child** (please circle) to receive dental treatment deemed necessary by the providers at Gary G. Linn, D.D.S., P.C. I certify that I have read and understand the information on this form and answered all questions to the best of my ability. I also realize that it is my responsibility to inform this office of any changes in my medical status. I understand providing incorrect information may be dangerous to my health. This consent shall be considered in effect until rescinded or revoked.

______________________________ ______________
(Printed name – Patient, Parent or Guardian) (Date)

______________________________ ______________
(Signature) (Date)

Thank You!