

Date ___/___/___

Sanford L. Barr, D.D.S.

Pt. Name: (Last,First,M): _____ Title: _____

Address: _____ Zip: _____

Hm Ph:(____) ____ - ____ Wk Ph:(____) ____ - ____ ex: ____ Cell Ph:(____) ____ - ____

E-Mail: _____@_____ Marital: Single ___ Married ___ Divorced ___ Widowed ___

Sex: M ___ F ___ Date of Birth: ___/___/___ Social Security # ___ - ___ - ___

Employer _____ Occupation _____

Who referred you to our office? _____

Primary Dental Insurance Coverage

Subscriber Name: _____ Relation to Pt.: Self ___ Spouse ___ Child ___ Other ___

Address: Same as Above ___ Other: _____

SS#: ___ - ___ - ___ Date of Birth ___/___/___ Employer: _____

Ins. Co. Name: _____ Group # _____

Ins. Co. Address: _____ Ph :(____) ____ - ____

Secondary Dental Insurance Coverage

Subscriber Name: _____ Relation to Pt.: Self ___ Spouse ___ Child ___ Other ___

Address: Same as Above ___ Other: _____

SS#: ___ - ___ - ___ Date of Birth ___/___/___ Employer: _____

Ins. Co. Name: _____ Group # _____

Ins. Co. Address: _____ Ph:(____) ____ - ____

Authorizations

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to this dentist or dental entity.

Pt./Guardian Signature _____

Date ___/___/___

I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims

Name of Responsible Party: (please print) _____

Signature of Responsible Party: _____

Date ___/___/___

**SANFORD L. BARR DENTAL OFFICE
PATIENT MEDICAL HISTORY**

PATIENT NAME: _____

FAMILY PHYSICIAN: _____ **PHONE:** _____

Do we have your permission to contact your personal physician if the need arises?

Yes _____ No _____

Are you currently under a Medical Doctors care for a physical condition? Yes _____ No _____

Please explain _____

Pharmacy: _____ Phone: _____

MEDICAL HISTORY

List All Medications: Non-Prescription & Prescription

List All Vitamins and Herbs you are taking:

Allergies-Check all that apply:

- Aspirin Erythromycin Metals Sulfa Latex
 Codeine Jewelry Penicillin Dental Anesthetics Tetracycline

Other: _____

For Women Only- Check all that apply:

- Are you taking birth control pills? Are you pregnant? # of weeks _____
 Are you nursing? Are you using Hormone Replacement?

Conditions: Please check if the following apply:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes I | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Diabetes II | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Fainting/Dizzy Spells |
| <input type="checkbox"/> Coumadin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke | <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> TMJ/TMD Problems |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> HIV+ AIDS | <input type="checkbox"/> Tonsils/Adenoids Removed |
| <input type="checkbox"/> Fever Blisters/Cold Sores | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Eye/Ear Disorder |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Psychiatric/Emotional Care | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Arthritis/Rheumatism |
| <input type="checkbox"/> Sleep Apnea/Excessive Snoring | <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> Hay Fever | |
| <input type="checkbox"/> Herpes (Any Kind) | <input type="checkbox"/> Anemia/Blood Disease | <input type="checkbox"/> Emphysema | |
| | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Problems | |
| | <input type="checkbox"/> Abnormal bleeding | | |

I attest these answers to be truthful and as complete as possible.

Signature: _____ Date: _____

PATIENT NAME: _____

DENTAL INFORMATION

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE NOW OR MAY HAVE HAD IN THE PAST:

Bleeding Gums
Swelling or Lumps in Mouth
Clenching or Grinding Teeth
Blisters/Sores on Lips or Mouth
Oral Habits, e.g. fingernail biting
Extensive Crown and Bridge-work

Bad Breath
Periodontal Treatment
Orthodontic Treatment
Mouth Breathing
Complications from Oral Surgery
Pain or Unusual sounds in Jaw, Joint, or Ear

CIRCLE ANY OF THE FOLLOWING THAT YOU USE:

Cigarettes, pipe, cigars _____ per day
Chewing tobacco
Pop and/or Juice intake _____ per day

Brush your teeth _____x/day
Electric toothbrush
Dental Floss _____x/week

Water Jet Device
Fluoride Supplements or Rinse



At present, do you have any dental concerns? _____

Have you experienced trauma to the jaw? No _____ Yes _____
(Explain) _____

What prompted you to seek dental care at this time? _____

Is there anything in your past dental history we should know about? No _____ Yes _____
(Explain) _____

Are you satisfied with your past dental care? _____

Date of last teeth cleaning: _____ Date of last dental X-rays: _____

Do you like the way your teeth look when you smile? No _____ Yes _____

