WELCOME TO OUR OFFICE

PATIENT NAME_____ **BIRTHDATE**_____ **AGE**____ **/ MALE**___ **FEMALE**___

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

PHONE HM#_____ **WK#**_____ **CELL#**_____

******* EMAIL ADDRESS** _____ ***Permission to contact you by email or text*: Yes** ___ **No** ____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ **RELATIONSHIP TO PATIENT**_____
SSN _____**/ ( ) SINGLE/ ( )MARRIED/ ( ) WIDOWED/ ( ) DIVORCED**

ARE YOU INSURED? YES__ or **NO** __ **/ POLICY HOLDER NAME** _____ **BIRTHDATE**_____
EMPLOYER_____ **INSURANCE COMPANY**_____
MEMBER ID #_____ **GROUP #**_____

ARE YOU COVERED BY ADDITIONAL INSURANCE? YES___ or **NO** ___
POLICY HOLDER NAME _____ **BIRTHDATE**_____
EMPLOYER_____ **INSURANCE COMPANY** _____
MEMBER ID #_____**GROUP #**_____

Assignment and release: I, the undersigned certify that I (or my dependent) have insurance coverage as stated above and assign directly to Dr. Opperman all insurance benefits, if any, otherwise payable to me for services rendered**. I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature_____**Date**_____**Relationship**_____

HEALTH HISTORY:

PHYSICIAN'S NAME: _____ **PHONE #** _____
PREVIOUS DENTIST_____ **PHONE #** _____

Do you or have you had any of the following:

__AIDS
__ANEMIA
__ARTHRITIS, RHEUMATISM
__ARTIFICIAL HEART VALVES
__ARTIFICIAL JOINTS_____
__ASTHMA
__BLEEDING ABNORMALLY
with extractions/ surgery
__BLOOD DISEASE
__CANCER
__CHEMICAL DEPENDENCY
__CHEMOTHERAPY
__CIRCULATORY PROBLEMS
__CONGENITAL HEART PROBLEM
__COUGH, PERSISTENT/BLOODY
__DIABETES
__DO/DID YOU USE DIET MEDICATIONS
__EMPHYSEMA
__EPILEPSY
__FAINTING OR DIZZINESS
__GLAUCOMA
__HEADACHES
__HEART MURMUR
__HEART PROBLEMS
__HEPATITIS "A" "B" "C"
__HERPES
__HIGH BLOOD PRESSURE
__HIV POSITIVE
__JAUNDICE
__KIDNEY DISEASE
__LIVER DISEASE
__LOW BLOOD PRESSURE
__MITRAL VALVE PROLAPSE
__NERVOUS PROBLEMS
__PACEMAKER
__ARE YOU PREGNANT
__PSYCHIATRIC CARE
__RADIATION THERAPY
__RESPIRATORY DISEASE
__RHEUMATIC FEVER
__SCARLET FEVER
__SHORTNESS OF BREATH
__SINUS TROUBLE
__SPECIAL DIET
__STROKE
__SWOLLEN NECK GLANDS
__THYROID PROBLEMS
__TONSILITIS
__TUBERCULOSIS
__TUMOR OR GROWTH
__ULCER
__VENEREAL DISEASE
__WEIGHTLOSS, UNEXPLAINED

__Do you use chewing tobacco?
__Do you smoke? _____

ALLERGIES: _____ ASPIRIN __ PENICILLIN __ SULFA__ CODEINE __ LATEX __ LOCAL ANESTHETIC__

OTHER ALLERGIES OR MEDICAL CONDITIONS NOT LISTED: _____

DENTAL HISTORY: Clicking/popping/pain of the jaw __ Bleeding gums __ Grinding teeth __

Please list any medications taken, including non-prescription drugs_____
_____

PHARMACY NAME_____ **ADDRESS**_____**PHONE#**_____
I hereby acknowledge all above questions and verify that what is stated is true to the best of my knowledge.

SIGNATURE_____ **DATE**_____