

Paul E. Barlow, D.D.S.
Associates
Family Dentistry

Welcome and thank you for selecting our dental healthcare team!

We will strive to provide you with the highest quality dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance please ask us.

Patient Information (CONFIDENTIAL) Soc. Sec. # _____ Home Phone _____ Cell Phone _____

Name (First) _____ (Middle) _____ (Last) _____ D.O.B. _____ Male Female

Mailing Address* _____ City _____ State _____ Zip _____

* If the above address is a PO Box, you must provide a street address for yourself

Check appropriate one: Minor Single Married E-mail Address _____

Patient's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse/Parents _____ Employer _____ Work Phone _____
(or Parent's name if Patient is a Minor)

Person to contact in Case of Emergency _____ Phone _____

Who may we thank for referring you? _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____

Address _____ Home Phone _____

Driver's License # _____ State _____ SS# _____ D.O.B. _____ Financial Institution _____

Employer _____ Work Phone _____
Company Name (Business Address)

Is this Person Currently a Patient in our Office? Yes No

Nearest Relative (not living with you) _____ Phone _____ Relationship _____

Insurance Information

Name of Insured _____ Relationship _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Insurance Billing Address _____ City _____ State _____ Zip _____ Phone _____

How much is your Deductible? _____ Max Annual Benefit _____ How Much Have You Used? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE: YES NO IF YES, COMPLETE THE FOLOWING:

Name of Insured _____ Relationship _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Insurance Billing Address _____ City _____ State _____ Zip _____ Phone _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?	Yes <input type="checkbox"/> No <input type="checkbox"/>	7. Are you allergic to or have you had any reactions to the following:	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness?	<input type="checkbox"/> <input type="checkbox"/>	- Local Anesthetics (e.g., Novocain)	<input type="checkbox"/> <input type="checkbox"/>
3. Are you taking any medication(s), including non-prescription medicine? If yes, what medication(s) are you taking: _____	<input type="checkbox"/> <input type="checkbox"/>	- Penicillin or other Antibiotics	<input type="checkbox"/> <input type="checkbox"/>
4. Do you use alcohol or tobacco?	<input type="checkbox"/> <input type="checkbox"/>	- Sulfa Drugs	<input type="checkbox"/> <input type="checkbox"/>
5. Do you use street or recreational drugs?	<input type="checkbox"/> <input type="checkbox"/>	- Barbiturates	<input type="checkbox"/> <input type="checkbox"/>
6. Are you wearing contact lenses	<input type="checkbox"/> <input type="checkbox"/>	- Sedatives	<input type="checkbox"/> <input type="checkbox"/>
9. Do you have or have you had any of the following?		- Iodine	<input type="checkbox"/> <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>	- Aspirin	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	- Other	<input type="checkbox"/> <input type="checkbox"/>
Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	8. Women only:	
Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/> <input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/> <input type="checkbox"/>	b) Are you nursing?	<input type="checkbox"/> <input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/> <input type="checkbox"/>	c) Are you taking birth control pills?	<input type="checkbox"/> <input type="checkbox"/>
Asthma	<input type="checkbox"/> <input type="checkbox"/>		
Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>		
Epilepsy / Convulsions	<input type="checkbox"/> <input type="checkbox"/>		
Leukemia	<input type="checkbox"/> <input type="checkbox"/>		
Diabetes	<input type="checkbox"/> <input type="checkbox"/>		
Kidney Diseases	<input type="checkbox"/> <input type="checkbox"/>		
AIDS or HIV Infection	<input type="checkbox"/> <input type="checkbox"/>		
Thyroid Problem	<input type="checkbox"/> <input type="checkbox"/>		

Patient Dental History

1. Do your gums bleed while brushing or flossing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	8. Do you have frequent headaches?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/> <input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/> <input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/> <input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/> <input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/> <input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/> <input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/> <input type="checkbox"/>	12. Have you ever had any orthodontic work?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/> <input type="checkbox"/>	13. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/> <input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?		14. Have you ever had instruction on the correct method of brushing your teeth?	<input type="checkbox"/> <input type="checkbox"/>
a) Clicking	<input type="checkbox"/> <input type="checkbox"/>	15. Have you ever had instruction on the care of your gums?	<input type="checkbox"/> <input type="checkbox"/>
b) Pain (joint, ear, side of face)?	<input type="checkbox"/> <input type="checkbox"/>		
c) Difficulty in opening or closing?	<input type="checkbox"/> <input type="checkbox"/>		
d) Difficulty in chewing?	<input type="checkbox"/> <input type="checkbox"/>		

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 payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or the 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. I agree to pay any additional 40% collection fees, and legal fees of collection with or without suit, including attorney fees and collection costs should this become necessary.

X _____ Date _____
Signature of patient or parent if minor

Doctor's Comments	
Signature _____	Date _____