LARRY ERWICH, D.M.D., P.C.
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Patient Information (Confidential)

Name ______________________________ Date ______________

SS# ______________ Birthdate ______________ Age ______________ Home Phone ______________

Address ______________ City ______________ State ______________ Zip ______________

Email ______________________________ Cell Phone ______________

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

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

Patient or Parent/Guardian's Employer ______________________________ Work Phone ______________

Business Address ______________ City ______________ State ______________ Zip ______________

Spouse or Parent/Guardian's Name ______________ Employer ______________ Work Phone ______________

Whom May We Thank for Referring You? ______________________________

Person to Contact in Case of Emergency ______________________________ Phone ______________

Previous Dentist ______________________________

Occupation ______________________________

Responsible Party

Name of Person Responsible for this Account ______________________________ Relationship to Patient ______________

Address ______________________________ Home Phone ______________

Email ______________________________ Cell Phone ______________

Birthdate ______________

Employer ______________ Work Phone ______________ SS# ______________

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

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard

Insurance Information

Name of Insured ______________________________ Relationship to Patient ______________

Birthdate ______________ SS# ______________ Date Employed ______________

Name of Employer ______________________________ Work Phone ______________

Employer Address ______________ 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

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Name of Insured ______________________________ Relationship to Patient ______________

Birthdate ______________ SS# ______________ Date Employed ______________

Name of Employer ______________________________ Work Phone ______________

Employer Address ______________ City ______________ State ______________ Zip ______________

Insurance Company ______________ Group # ______________ Policy/ID # ______________

Ins. Co. Address ______________ City ______________ State ______________ Zip ______________

I understand that I am responsible for all costs of dental treatment including outstanding insurance balances in excess of 45 days. Payment on all balances is due within 30 days. Interest 1¼ % per month 15% per year will be added to patient balances past due. I promise to pay any collection and attorney fees in any effort to collect on this account. I hereby authorize Dr. Erwich's office to administer medications and perform diagnostic and therapeutic procedures as may be necessary for my dental treatment.

Over Please

Physician ______________________ Office Phone ______________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Do you require antibiotics before dental treatment?	☐	☐
8. Do you have or have you had any of the following?	☐	☐

	Yes	No
9. Are you allergic to or have you had any reactions to the following:		
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________	☐	☐
10. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Mitral Valve Prolapse	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Swollen Ankles	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other ______________	☐	☐

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. How often do you brush? ______________	☐	☐
16. Type of bristles Soft Medium Hard	☐	☐
17. How often do you floss? ______________	☐	☐
18. Do you like your smile?	☐	☐
19. Have you ever bleached your teeth/would you like to discuss?	☐	☐

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/guardian if minor)