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Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Middle initial
Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex: Male ___ Female ___ Age ___ Birthdate _____ Single ___ Married ___ Widowed ___ Separated ___ Divorced ___
Patient Employer _____ Occupation _____
Business Address _____
Business Phone _____ Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Phone number _____
Cell Phone _____ Business Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial
Relation to Patient _____ Birthdate _____ Soc. Sec.# _____
Address (if different from patient) _____ Home Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ Phone _____
Contract# _____ Group# _____ Subscriber# _____
Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes ___ No ___
Subscriber Name _____ Relation to patient _____ Birthdate _____
Address (if different from patient) _____ Soc. Sec.# _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Subscriber Employed by _____ Business Phone _____
Insurance Company _____ Phone _____
Contract# _____ Group# _____ Subscriber# _____

Dental History

Reason for first visit _____ Are you in dental discomfort? _____

Former Dentist _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date of last dental care _____ Date of last dental xrays _____

Check yes or no if you have a history of the following:

Yes ___ No ___ Bad Breath Yes ___ No ___ Food collection between teeth Yes ___ No ___ Broken fillings Yes ___ No ___ Bleeding Gums
Yes ___ No ___ Sensitivity to ___ Cold ___ Sweets ___ Heat ___ When biting or chewing? Yes ___ No ___ Clicking or Popping Jaw
Yes ___ No ___ Sores or growth in mouth Yes ___ No ___ Loose teeth Yes ___ No ___ Orthodontic treatment Yes ___ No ___ Periodontal treatment

How often do you brush? _____ How often do you floss _____ Are you happy with the appearance of your teeth? _____

Are you apprehensive about dental treatment? _____ Have you had any problems with previous dental treatment? _____

Please explain _____

Medical History

Physician's Name _____ Phone Number _____

Date of Last visit _____ Have you had any operations or serious illnesses? _____

If yes, describe _____

Are you currently under physician care? _____ If yes, describe _____

Have you ever had a blood transfusion? _____ If yes, give approximate dates _____

Women: Are you pregnant? _____ Nursing? _____ Taking birth control pills? _____ Reached menopause? _____

Check yes or no if you have had any of the following:

Yes ___ No ___ Abnormal bleeding	Yes ___ No ___ Cough, persistent	Yes ___ No ___ Intestinal problems	Yes ___ No ___ Shortness of Breath
Yes ___ No ___ AIDS/HIV Positive	Yes ___ No ___ Diabetes	Yes ___ No ___ Kidney disease	Yes ___ No ___ Skin Rash
Yes ___ No ___ Anaphylaxis	Yes ___ No ___ Epilepsy	Yes ___ No ___ Liver disease	Yes ___ No ___ Spina Bifida
Yes ___ No ___ Anemia	Yes ___ No ___ Fainting	Yes ___ No ___ Material allergies	Yes ___ No ___ Stroke
Yes ___ No ___ Arthritis	Yes ___ No ___ Food allergies	(latex, metal, chemicals)	Yes ___ No ___ Surgical implant
Yes ___ No ___ Artificial Heart Valve	Yes ___ No ___ Glaucoma	Yes ___ No ___ Mitral valve prolapse	Yes ___ No ___ Swelling of feet or ankles
Yes ___ No ___ Artificial Joints	Yes ___ No ___ Hay Fever	Yes ___ No ___ Nervousness	Yes ___ No ___ Thyroid disease or malfunction
Yes ___ No ___ Asthma	Yes ___ No ___ Headaches	Yes ___ No ___ Pacemaker	Yes ___ No ___ Tobacco habit
Yes ___ No ___ Back Problems	Yes ___ No ___ Head Injury	Yes ___ No ___ Psychiatric Care	Yes ___ No ___ Tonsillitis
Yes ___ No ___ Blood disease	Yes ___ No ___ Heart Murmur	Yes ___ No ___ Radiation treatment	Yes ___ No ___ Tuberculosis
Yes ___ No ___ Cancer	Yes ___ No ___ Heart Problems	Yes ___ No ___ Respiratory disease	Yes ___ No ___ Ulcer/Colitis
Yes ___ No ___ Chemical dependency	Describe _____	Yes ___ No ___ Rheumatic or	Yes ___ No ___ Venereal Disease
Yes ___ No ___ Chemotherapy	Yes ___ No ___ Herpes	Scarlet Fever	
Yes ___ No ___ Cortisone treatments	Yes ___ No ___ High blood pressure	Yes ___ No ___ Shingles	

Is patient currently taking any medications? If yes, list all:

Does patient have drug allergies? If yes, list all:

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.