# Black & Black Dental LLC

2600 Willow Street Pike South
Willow Street, PA 17584
717-464-3223

## Patient Information

*Thank you for choosing our practice for your dental needs. Please complete this form in ink.*
*If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

(Please Print)

Name ______________________________ Date __________
First Middle Initial Last

Social Security # ______________ Insurance ID# ______________

Address ______________ City ______________ State ______ Zip ______

Sex: ☐Female ☐Male Birthdate ______________ E-mail ______________

Home Phone (______) ______________ Cell Phone (______) ______________ Work Phone (______) ______________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ____ years

Patient Employer/School ______________ Occupation ______________

Employer/School Address ______________ City ______________ State ______ Zip ______

Spouse or parent's name ______________ Employer ______________ Work Phone (______) ______________

Whom may we thank for referring you to us? ______________

Person to contact in case of emergency ______________ Phone (______) ______________

## Responsible Party

Name of person responsible for this account ______________

Relationship to patient ______________ Phone (______) ______________

Address ______________ City ______________ State ______ Zip ______

Name of Employer ______________ Work Phone (______) ______________

## Insurance Information

Name of insured ______________ Relationship to patient ______________

Birthdate ______________ Social Security # ______________ Date employed ______________

Name of employer ______________ Work Phone (______) ______________

Address ______________ City ______________ State ______ Zip ______

Insurance Co. ______________ Group # ______________ Employee # ______________

Insurance Co. Address ______________ City ______________ State ______ Zip ______

How much is your deductible? ______________ How much have you used? ______________ Max. Annual benefit? ______________

DO YOU HAVE ADDITIONAL INSURANCE? ☐ No ☐ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured ______________ Relationship to patient ______________

Birth date ______________ Social Security # ______________ Date employed ______________

Name of Employer ______________ Work Phone (______) ______________

Address ______________ City ______________ State ______ Zip ______

Insurance Co. ______________

Group # ______________ Employee # ______________

Insurance Co. Address ______________ City ______________ State ______ Zip ______

How much is your deductible? ______________ How much have you used? ______________ Max. Annual benefit? ______________

# Dental History

Name ______________________ Age ______ Date of last exam ______

Former Dentist ______________________ Date of last dental x-rays ______________

Reason for today's visit ______________________

How often do you brush? ______________ How often do you floss? ______________

Please check (✓) any of the following conditions that apply to you:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping in jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

# Medical History

Physician ______________________ Date of last visit ______________

Please list **ALL** medications you are currently taking: ______________________

Allergies: ______________________

(Women) Are you pregnant ❑Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✓) if you have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis/Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital Heart lesions
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
  Describe ______________
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Hernia Repair
- ❑ High Blood Pressure
- ❑ Hip/Knee Replacements
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Latex Allergies
- ❑ Liver Disease
- ❑ Metal Allergies
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problemr
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of the Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

Are you currently taking, or have you ever taken any of these medications?

**Blood Thinners:** ❑ Coumadin ❑ Plavix ❑ Warfarin

**Other:** ❑ Fosomax ❑ Levoxyl ❑ Synthroid

# Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my duty to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________
Name of Insurance Company(ies)

and assign directly to Dr. ______________ 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

______________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________ ______________
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient