Cleveland Family
DENTISTRY
Vic Uhrenholdt DDS, FAGD
Nan Rosas DDS

## Patient Information

Date: _____

Name: _____ _____ Soc. Sec #: _____

Address: _____ D. L. #: _____

City: _____State: _____ Zip: _____ E-Mail: _____

Cell Phone: _____Home Phone: _____Work Phone: _____

Sex: ◯ M ◯ F Age: _____Birthdate: _____ ◯ Minor ◯ Single ◯ Married

Patient Employer/School: _____ Occupation: _____

Employer Address: _____ Phone #: _____

How would you like our office to confirm your appointments? ◯ Phone ◯ Text ◯ E-mail

In case of emergency, who should be notified? _____Phone # _____

**Referral Information – Whom may we thank for referring you to our practice?**

◯ Patient/Friend ◯ Our Staff ◯ Yellow Pages ◯ Work ◯ Our Sign ◯ School ◯ Work

◯ Patient/Relative ◯ Newsletter ◯ Website ◯ Facebook ◯ Google ◯ Other _____

Name of the person or office referring you to our practice: _____

**Medical History**

Physicians Name: _____Phone #: _____

Have you had any serious illnesses or operations? Yes ◯ No ◯ If Yes, Describe: _____

Are you taking any blood thinners? Yes ◯ No ◯ Please List: _____

Do you have to be pre-medicated before any dental treatments? ◯Yes ◯No Reason: _____

Do you have any other medical problem or medical history NOT on this form? ◯ Yes ◯ No

Please List: _____

**WOMEN ONLY**

Are you pregnant? ◯ Yes ◯ No Are you nursing? ◯ Yes ◯ No Taking birth control pills? ◯ Yes ◯ No

## Sleep Wellness:

| | | |
|---|---|---|
| Has anyone ever told you that you snore? | ◯ Yes | ◯ No |
| Do you often feel tired, fatigued, or sleepy during the day? | ◯ Yes | ◯ No |
| Has anyone observed you stop breathing during your sleep? | ◯ Yes | ◯ No |
| Do you use a CPAP machine? | ◯ Yes | ◯ No |

## Check if you have or have had any of the following:

| | | | |
|---|---|---|---|
| ◯ Anemia | ◯ Cancer | ◯ Heart Problems | ◯ Mitral Valve Prolapse |
| ◯ Arthritis | ◯ Chemotherapy | ◯ Hepatitis | ◯ Pacemaker |
| ◯ Artificial Heart Valve | ◯ Diabetes | ◯ High Blood Pressure | ◯ Respiratory Disease |
| ◯ Artificial Joints | ◯ Epilepsy | ◯ HIV/AIDS | ◯ Rheumatic Fever |
| ◯ Asthma | ◯ Fainting | ◯ Jaw / TMJ Pain | ◯ Stroke |
| ◯ Back Problems | ◯ Headaches | ◯ Liver/Kidney Disease | ◯ Use Tobacco/Smoke |

**Are you allergic to any of the following?**

◯ Penicillin ◯ Aspirin ◯ Local Anesthetics ◯ Codeine ◯ Latex ◯ Sulfa Drugs
◯ Other _____

**Please list all medications you are currently taking**

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____

**Dental History**

Reason for today's visit: _____
Previous Dentist: _____ Last Visit: _____
Reason for changing dentist: _____
Are you nervous about seeing a dentist? ◯ Yes ◯ No If yes, please tell us why:_____

| | | | | | |
|---|---|---|---|---|---|
| Are any of your teeth sensitive? | Yes | No | I have problems eating | Yes | No |
| I clench/grind my teeth | Yes | No | I have had orthodontics | Yes | No |
| My gums bleed while brushing/flossing | Yes | No | I like my smile | Yes | No |
| I have loose teeth or broken fillings | Yes | No | I want my teeth straight | Yes | No |
| I hear clicking or popping in my jaw | Yes | No | I want my teeth whiter | Yes | No |

**Responsible Party**
Name of insurer: _____ Social Security# _____
Relationship to patient: _____ Birthdate: _____
Address (if different from patient): _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Person insured employed by: _____ Occupation: _____
Insurance Company: _____ Phone #_____
Group #: _____ Subscriber: _____
Name of other dependents covered under plan: _____

**We accept Cash, Check, Visa, Mastercard, Discover**
**Financing available through Care Credit - Ask us how!**

As a courtesy, we are happy to assist you in filing your dental insurance. We are an out of network provider for all insurance companies. We will collect your estimate portion on the day of service and will wait 30 days to obtain the balance from your insurance company. Any portion not paid by your insurance company in 30 days will be collected from the patient. Our doctors will provide dental care based on your needs and will not be based on what your insurance may or may not cover. Our goal is to provide you with exceptional service in obtaining excellent oral health.

**The patient or guarantor is responsible for the fee at the time of treatment unless prior arrangements have been approved**.

I understand that the fee quoted will be valid for a period of 12 months from the date of the patient examination. I hereby authorize payment to Cleveland Family Dentistry for my insurance benefits. I understand that I'm ultimately responsible for all costs for the dental treatment. I grant the right to Cleveland Family Dentistry to release my dental/medical histories and other information about my dental treatment to third party payers.

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Patient Insured: _____ Date: _____