WELCOME

Gina Prokosch-Cook, D.D.S. - Family Dentistry

Patient Information

Date _____

Patient _____

Social Security Number _____ - _____ - _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Date of Birth _____Age _____

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone _____

Married Widowed Single Minor

Separated Divorced Partnered

Referred by _____

Phone Numbers

Home_____ Work_____ Cell Phone_____

Best time and place to reach you_____

In Case of Emergency

Name _____ Phone Number _____

Relationship _____ Cell Phone _____

Dental Insurance

Who is responsible for this account? _____

Relationship to patient _____

PRIMARY INSURANCE

Dental Insurance Company _____

Address _____

Subscriber's Name _____

Relationship to patient _____

Birthdate _____

Social Security Number _____

Group Number _____

Employer _____

SECONDARY INSURANCE

Dental Insurance Company _____

Address _____

Subscriber's Name _____

Relationship to patient _____

Birthdate _____

Social Security Number _____

Group Number _____

Employer _____

Assignment and Release

All Insurance Subscribers

I certify that I , and/or my dependent(s), have insurance coverage with a plan that Dr. Cook is not a participant in. **I agree to pay Dr. Cook for all services rendered at the time of visit.** Insurance forms will be provided by Dr. Cook as a convenience. I understand that these forms can be submitted for my reimbursement

_____

Signature of Patient/Parent/Guardian Date

Name _____ Date of Birth _____

Dental Health History

Reason for today's Visit _____

Former Dentist_____

City/State_____

Date of last Dental Visit_____

Date of Last Dental Xrays _____

How often do you brush? _____

How often do you floss? _____

Do you need antibiotics before dental treatment? YES O NO O

Condition_____

Treating Physician _____

Address _____

Phone Number _____

Bleeding/Swollen gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Jaw pain/popping	☐ Yes	☐ No
Loose teeth/Broken fillings	☐ Yes	☐ No
Orthodontic Treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal Treatment	☐ Yes	☐ No
Sensitivity to hot/cold/sweets	☐ Yes	☐ No
Sores or growths in mouth	☐ Yes	☐ No

Medical Health History

Primary Care Physician _____ Phone _____

AIDS/HIV	O Yes	O No	Chemotherapy	O Yes	O No	Scarlet Fever	O Yes	O No
Anemia	O Yes	O No	Circulatory Problems	O Yes	O No	Sinus Trouble	O Yes	O No
Arthritis	O Yes	O No	Congenital Heart Lesion	O Yes	O No	Stroke	O Yes	O No
Asthma	O Yes	O No	Cortisone Treatment	O Yes	O No	Swollen Neck Glands	O Yes	O No
Artificial Joints	O Yes	O No	Diabetes	O Yes	O No	Thyroid Problems	O Yes	O No
What Joint? _____ Year Placed_____			Emphysema	O Yes	O No	Tonsillitis	O Yes	O No
Artificial Heart Valve	O Yes	O No	Epilepsy	O Yes	O No	Tuberculosis	O Yes	O No
Back Problems	O Yes	O No	Heart Murmur	O Yes	O No	Tumor on head/neck	O Yes	O No
Bleeding Abnormally With Extractions or surgery	O Yes	O No	Heart Problems	O Yes	O No		O Yes	O No
Blood Disease	O Yes	O No	Hepatitis Type____	O Yes	O No			
Cancer	O Yes	O No	High Blood Pressure	O Yes	O No			
Chemical Dependency	O Yes	O No	Radiation Treatment	O Yes	O No			
			Respiratory Disease	O Yes	O No			
			Rheumatic Fever	O Yes	O No			

Women:
Are you pregnant? O Yes O No
due date _____
Taking birth control pills?O Yes O No
Are you nursing? O Yes O No

Medications

List any **medications** you are currently taking, the **dosage** and **correlating diagnosis**:

_____

_____

_____

_____

_____

Are you currently taking blood thinners? O Yes O No

Have you had any recent surgeries? O Yes O No

Allergies

O Aspirin/ Ibuprofen
O Codeine
O Gluten
O Local Anesthetic
O Latex
O Penicillin
O Sulfa
O Other Medicine Allergy _____
O Other Food/Dye Allergy _____
O Other Allergy _____

Notice of Privacy Practices

I acknowledge that I have read and understood the **Privacy Practices** of *Dr. Gina Prokosch-Cook*, and authorize the use of my health information accordingly.

Name _____ Relationship to patient _____

Signature _____ Date _____

Financial Policy & Agreement

Gina Prokosch-Cook, D.D.S. - Family Dentistry

Payments for services rendered is due in full at the time of service. Our office accepts cash, personal checks and credit cards (Visa, MasterCard and Discover). There is a $25 returned check fee due and payable from you for each check payment returned to us by your bank.

Appointments

48 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 per half hour will be added to your account.

Out of Network Insurance Subscribers

The balance is due at the time of service. As a courtesy, insurance forms will be provided. These insurance forms can be submitted for your reimbursement..

Divorced/Separated Parents of Minor Patients

The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Our office will not be involved with separation or divorce disputes.

Financial Agreement

I agree to pay all fees and charges for myself and members of my family shown by statement, promptly and upon presentation thereof. I understand that I am responsible for timely payment of my account, as outlined above. I understand that should it become necessary to use an outside agency to collect payment, I am additionally responsible for any charges that may incur from this.

Printed Name _____

Signature _____

Date _____