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 ______________________________

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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 ________________

Who is responsible for this account? ________________

Relationship to patient ________________

Dental Insurance

PRIMARY INSURANCE

Dental Insurance Company ________________

Address ________________

Subscriber's Name ________________

Relationship to patient ________________

Birthdate ________________

Social Security Number ________________

Group Number ________________

Employer ________________

ID # ________________

SECONDARY INSURANCE

Dental Insurance Co ________________

Address ________________

Subscriber ________________

Relationship to patient ________________

Birthdate ________________

Social Security Number ________________

Group Number ________________

Employer ________________

ID# ________________

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

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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 X rays ______________________

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 What Joint? ______ Year Placed ______	O Yes	O No	Diabetes	O Yes	O No	Thyroid Problems	O Yes	O No
			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**:

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____

____

____

____

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 $40 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 $40 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 ____