ZUBKE FAMILY DENTISTRY

1106 First Avenue South • Escanaba, MI 49829 (906)786-3891

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ * _____ * ___ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **Prev. Visit:** _____ **Email Address:**

_____

Phone: _____ * _____ _____ ____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ * _____
Address 1 Address 2

_____ * ____ * ____-____ *
City State Zip Code

Child's Father's Name/Address

_____

_____

Child's Mother's Name/Address

_____

_____

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Email Address:** _____

Phone: _____ _____ _____ ____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ ____ ____-____
City State Zip Code

Relationship to patient _____

Primary Insurance

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Secondary Insurance

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Assignment and Release

I, the undersigned, have insurance coverage with the above stated and assign directly to Zubke Family Dentistry, PLLC, all dental benefits, if any, otherwise payable to me for services rendered. In consideration of services provided, I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions. I hereby assign and transfer to Zubke Family Dentistry, PLLC any and all rights which I have against insurance companies or third party payers, for payment of charges for services provided by Zubke Family Dentistry, PLLC to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Zubke Family Dentistry, PLLC. If my account is placed with a collection agency, an additional 35% will be added to my balance. It is our policy that any insurance copays and deductibles or any balance of a bill by those without insurance is due at the time of service.

Signature _____ **Date** _____

Medical Questions

Name of Physician _____

Pharmacy _____

Have there been any changes in your health in the last year? ◯ Yes ◯ No

Are you under the care of a physician? ◯ Yes ◯ No

Have you had any serious illnesses or operations? ◯ Yes ◯ No

Have you ever taken any drugs referred to as "fen-Phen"? These include combinations of Adipex or Fastin (phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine).

◯ Yes ◯ No

Have you ever had IV bisphosphonate treatment? ◯ Yes ◯ No

Are you pregnant? ◯ Yes ◯ No

Do you use any tobacco products? ◯ Yes ◯ No

Have you ever been told you require premedication prior to dental treatment? ◯ Yes ◯ No

Please explain any "yes" answers:

_____

_____

Please check if you have (or have had) any of the following problems.

☐ Anemia	☐ Anorexia/Bulemia	☐ Arthritis	☐ Artificial heart valve(s)
☐ Asthma	☐ Blood disease	☐ Cancer*	☐ Chemical dependency
☐ Chemotherapy/radiation therapy	☐ Circulation problems	☐ Diabetes	☐ Emphysema
☐ Epilepsy	☐ Fainting	☐ Headaches (frequent/severe)	☐ Hearing loss
☐ Heart murmur	☐ Heart (any problems)*	☐ Hemophilia	☐ Herpes
☐ Hepatits*	☐ High blood pressure	☐ HIV	☐ Jaw pain
☐ Joint replacement*	☐ Kidney Disease	☐ Liver Disease	☐ Low blood pressure
☐ Nervous problems	☐ Pacemaker	☐ Psychiatric care	☐ Respiratory disease
☐ Rheumatic fever	☐ Scarlet Fever	☐ Seizure disorders	☐ Shortness of breath
☐ Sinus problems	☐ Stroke	☐ Surgical implants	☐ Swelling (feet or ankles)
☐ Thyroid problems	☐ Tuberculosis	☐ Other*	☐ None of these

*** Please explain below**

_____

_____

_____

Allergies (Please List)

_____

_____

Patient's Medications

Please list any medications (prescription, non-prescription, and/or supplements) you are currently taking.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dental History

Reason for today's visit _____

Do you like your smile? _____

Does dental work make you nervous? _____

How often do you brush? _____

How often do you floss? _____

New Patients:
Former dentist and date of last dental visit? _____

Do you have/have you had any of the following?

☐ Bad breath	☐ Bleeding gums	☐ Broken filling(s)/teeth	☐ Clicking or popping jaw
☐ Food collection between teeth	☐ Grinding/clenching teeth	☐ Loose teeth	☐ Periodontal treatment
☐ Sensitivity to hot/cold	☐ Sensitivity to sweets	☐ Sensitivity when biting	☐ Sores or growths in your mouth

☐ **I certify that this medical information is true and correct to the best of my knowedge.**

Signature _____ **Date** _____

Response Date: _____