john luber DDS | comprehensive family and cosmetic dentistry

PATIENT INFORMATION

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Name _____ SS# _____
Last First Middle Preferred

Status: **Married** **Widowed** **Single** **Minor** **Separated** **Divorced**

Address _____ City_____ State_____ Zip Code_____

Please circle preference of appointment confirmation: **E-Mail** **Home Phone** **Cell Phone** **Work Phone**

E-Mail Address _____ Sex **M** or **F** Birth Date_____

Responsible Party Name (if patient is minor) _____Relationship to Minor_____

Patient Employer _____Occupation _____

Employer Address _____ Employer Phone _____

Spouse's Name _____ Do you have children? **Y** or **N** How many ?_____

In case of an emergency, who should be notified? _____ Phone ( )_____

Who may we thank for referring you to our office? _____

PRIMARY DENTAL INSURANCE

Name of Dental Insurance Company:
_____
Insurance Claims Address:
_____
Insurance Group # _____
Insurance Phone # _____
Policyholder's Name: _____
Policyholder's Employer: _____
Policyholder's Employer Phone #: _____
Policyholder's ID#/SS# _____
Policyholder's Birth Date: _____
Policyholder's Phone # _____
Relationship to Policyholder_____

SECONDARY DENTAL INSURANCE

Name of Dental Insurance Company:
_____
Insurance Claims Address:
_____
Insurance Group # _____
Insurance Phone # _____
Policyholder's Name: _____
Policyholder's Employer: _____
Policyholder's Employer Phone #: _____
Policyholder's ID#/SS# _____
Policyholder's Birth Date: _____
Policyholder's Phone # _____
Relationship to Policyholder_____

Authorization

I hereby authorize payment directly to **John G. Luber D.D.S.** of the group benefits otherwise payable to me. I understand all treatment rendered is my responsibility regardless of any insurance coverage. If insurance coverage is available to me, I understand it is a contract between the insurance company and myself I hereby authorize John G. Luber D.D.S. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Signature_____Date_____
Patient Guardian Other

Dental History

Reason for today's visit **Exam** **Emergency** **Consultation** Are you in pain? **Y** **N** How long?_____
List any dental concerns and discomforts _____
When was your last dental visit?_____
Would you describe your dental health as good? Comments_____
Do you have active decay or gum disease? _____Do your gums bleed? Describe _____
Do you brush and floss on a routine basis? How often?_____
Have you ever had a bad experience in a dental office? Describe_____

Have you ever had orthodontic treatment (Braces)?_____ YES NO
Do you smoke or use any tobacco? _____ YES NO
Do you clench or grind your teeth during the day or night?_____ YES NO
Do you experience excessive daytime sleepiness? Do you snore?_____YES NO
Do you feel nervous about dental work? _____YES NO

Medical History

Medical doctor's name _____ Phone ( ) _____
Are you under a doctor's care? Why?_____
Have you been hospitalized in the last two years? Why? _____
Are you pregnant? (women) _____

Please list ALL Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you allergic to any Medications or Substances?

_____
_____
_____
_____
_____

Please CIRCLE if you have or had any of the following:

Heart Trouble	Hay Fever	Blood disease
Shortness of Breath	Sinus Trouble	Cortisone Medicine
High Blood Pressure	Allergies	Bruise easily
Low Blood Pressure	Emphysema	Sickle cell anemia
Heart Murmur	Tuberculosis	Blood transfusion
High Cholesterol	Lung Disease	Kidney trouble
Mitral Valve Prolapse	Scarlet Fever	Ulcers
Heart Pacemaker	Thyroid Disease	Cold Sores/Fever Blisters
Congenital Heart Lesion	Hypoglycemia	Stroke
Artificial Heart Valve	Excessive Thirst	Yellow jaundice
Rheumatic Fever	Diabetes	Drug addiction
Swelling of Feet/Ankles	Hepatitis (other)	Psychiatric care
Heart Surgery	Hepatitis B (serum)	Nervousness
Anemia	Hepatitis A (infection)	Epilepsy or Seizures
Glaucoma	Cancer	Liver disease
Pain in jaw joint	X-ray or Cobalt TX	Herpes
Rheumatism	Chemotherapy	Migraine Headaches
Arthritis/ Gout	Radiation Therapy	FEN PHEN / REDUX
Fainting/Dizziness	AIDS	(last taken_____)
Frequent Fever	Venereal Disease	Osteoporosis/Osteopenia
Asthma	Hemophilia	Artificial Joints/Hips
Chest Pain	Parathyroid disease	

Have you ever had any serious illness **not** listed above? What? _____

(For office use only) **Medical Updates**

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Reviewed by Doctor_____ Date_____ B.P. _____