



**PATIENT HEALTH RECORD**  
(Please Print)

*A and A Dental*  
Alan P. Gross D.D.S Abigale P. Neville D.M.D

DATE \_\_\_\_\_ REFERRED BY \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX M F

MARITAL STATUS \_\_\_\_\_ S.S.# \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY/TOWN \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT? \_\_\_\_\_ SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ PARENT

RESPONSIBLE PARTY NAME \_\_\_\_\_

DO YOU HAVE DENTAL INSURANCE \_\_\_\_\_ YES \_\_\_\_\_ NO COMPANY \_\_\_\_\_

SPOUSE: NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SS # \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_ ADDRESS \_\_\_\_\_

DOES SPOUSE HAVE DENTAL INS. \_\_\_\_\_ YES \_\_\_\_\_ NO COMPANY \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

NAME ADDRESS

**SIGNATURE AUTHORIZATION**

By signing this section below, I am giving the office of A and A Dental permission to stamp "Signature Authorization" on any unsigned dental insurance claim forms. This will expediate our filing and processing these forms on your behalf.

*I have reviewed the following treatment plan and authorize the release of any information relating to this claim.*

\_\_\_\_\_  
SIGNED (patient, or parent if minor) DATE

*I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.*

\_\_\_\_\_  
SIGNED (insured person) DATE

CHECK ( ) EITHER "YES" OR "NO"  
(for assistance in completing form, please ask)

	YES	NO	YES	NO
1. Are you presently in pain? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you under medical treatment now? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication now? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
what? _____ for what purpose? _____				
4. Are you allergic to penicillin or have had an adverse response to any other drug? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
which drug? _____				
5. Have you ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
for what? _____				
6. Have you ever been treated for:				
Heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease, Hepatitis, Jaundice .....	<input type="checkbox"/>
MVP/Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>
Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease .....	<input type="checkbox"/>
High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>
Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths .....	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>
Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Emphysema .....	<input type="checkbox"/>
Mental problems or nervous disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble .....	<input type="checkbox"/>
Kidney trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive/AIDS .....	<input type="checkbox"/>
			Were you ever told you couldn't donate blood? .....	<input type="checkbox"/>
			Other .....	<input type="checkbox"/>
7. Do you often have spells of dizziness or fainting? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does anyone in your family have diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
who? _____				
9. (Women) Are you pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had severe bleeding after extraction of teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you smoke, chew tobacco, or have other oral habits? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you in good health at this time? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I consent to treatment as necessary or desirable. I also acknowledge full responsibility for payment for such treatment.  
\*I understand that unpaid balances are subject to a monthly charge of 1.5% in addition to late fees.

Signed \_\_\_\_\_  
patient, parent or guardian (must be 18 years or older)