Print Form

Byron R. Rome, DDS, APDC

306 S. Burnside Avenue • Gonzales, LA 70737 • (225) 621-2700 • Fax (225) 644-0493 • www.drromedental.com

Adult Health/Dental History Form

ABOUT YOU

Last Name_____ First Name_____ M.I._____
What you prefer to be called:_____
Birthdate____/____/____ Age_____ SS#_____ Gender ❑ Male ❑ Female
Address_____ City_____ ST_____ Zip_____
Home Phone:_____ Work Phone_____ Cell Phone_____
Email Address_____ Referred by_____
Employer_____ Occupation_____
Address_____ City_____ ST_____ Zip_____
Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed Spouse's Name_____
Do you have children? ❑ Yes ❑ No How Many?_____

INSURANCE INFORMATION

Primary Insurance Company_____ Phone (____) ____-____
Address:_____ City_____ ST_____ Zip_____
Insured's ID#_____ Group ID# _____
Insured's Name_____ Relation_____ Date of Birth_____
Insured's Employer_____
Secondary Insurance Company_____ Phone (____) ____-____
Address:_____ City_____ ST_____ Zip_____
Insured's ID#_____ Group ID# _____
Insured's Name_____ Relation_____ Date of Birth_____
Insured's Employer_____

ACCOUNT INFO

Person ultimately responsible for account

Name_____ Relation_____
Billing Address:_____ City_____ ST_____ Zip_____
SS#_____ Driver's License #_____ Work Phone (____) ____-____
Payment Method: ❑ Cash ❑ Check ❑ Credit Card # _____ Exp____/____
I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office). *Initials*_____

IN THE EVENT OF AN EMERGENCY

Whom should we contact?_____ Relation_____
Home Phone (____) ____-____ Cell Phone (____) ____-____ Work Phone (____) ____-____
Who is your medical doctor?_____ Office Phone (____) ____-____

DENTAL INFORMATION

Reason for today's visit ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How long?_____
Please indicate any of the following problems you are experiencing:

❑ Discomfort, clicking/popping in jaw ❑ Locking jaw ❑ Broken/Chipped tooth
❑ Lost/Broken Filling(s) ❑ Red, swollen or bleeding gums ❑ Sensitive tooth, teeth or gums
❑ Stained teeth ❑ Teeth grinding ❑ Blisters/Sores in/ around the mouth
❑ Bad Breath ❑ Ringing in Ears ❑ Other_____

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Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Last Dental Exam __/__/___ Dental X-rays __/__/___
Previous Dentist_____ Phone_(_____)_____-_____
Times a day you brush?_____ Times a week you floss? _____ Type of toothbrush bristle used: ❑ Soft ❑Medium ❑Hard
How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

What medications do you take? ❑ Nerve Pills ❑ Pain Killers ❑ Muscle Relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ Others_____
Have you ever taken: Bisphosphonates *(ex. Aredia/Fosamax)* ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No
Do you have or have you had any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Heart Attack / Stroke	❑	❑	Thyroid Problems	❑	❑	Cancer/Tumors	❑	❑	Cosmetic Surgery
❑	❑	Heart Surg./Pacemaker	❑	❑	Kidney Problems	❑	❑	Shingles	❑	❑	Xray or Cobalt Treatment
❑	❑	Heart Murmur	❑	❑	Liver Problems	❑	❑	Hepatitis	❑	❑	Chemotherapy
❑	❑	Rheumatic Fever	❑	❑	Respiratory Problems	❑	❑	HIV+/AIDS/ARC	❑	❑	Asthma
❑	❑	Mitral Valve Prolapse	❑	❑	Sinus Problems	❑	❑	Arthritis/Rheumatism	❑	❑	Difficulty Breathing
❑	❑	Artificial Valves	❑	❑	Stomach Problems/Ulcers	❑	❑	Artificial Bones/Joints	❑	❑	Diabetes/Hypoglycemia
❑	❑	Heart Disease	❑	❑	Psychiatric Problems	❑	❑	Emphysema	❑	❑	Leukemia
❑	❑	Congenital Heart Defect	❑	❑	Venereal Disease	❑	❑	Fainting/Seizures/Epilepsy	❑	❑	Anemia
❑	❑	Chest Pains	❑	❑	Alcohol/Drug Abuse	❑	❑	Severe/Frequent Headaches	❑	❑	High/Low Blood Pressure
❑	❑	Scarlet Fever	❑	❑	Tuberculosis TB	❑	❑	Frequent Neck Pain	❑	❑	Bleeding Problems
❑	❑	Nervousness	❑	❑	Jaw Problems TMJ/TDM	❑	❑	Back Problems	❑	❑	Glaucoma

Please list any other surgeries or medical conditions you have or ever had:_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Asprin
❑ Dental Anesthetics ❑ Foods_____ ❑ Other_____
Do you use tobacco? ❑ No ❑ Yes/How used?_____How much?_____ How long?_____
Please rate your general health from 1-10 _____ Do you wear contact lenses? ❑ Yes ❑ No
For Women: Are you taking birth control pills? ❑ Yes ❑ No How many children have you had?_____
Are you pregnant? ❑ No ❑ Yes/How long?_____ Are you nursing? ❑ Yes ❑ No

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

UPDATE (Office Use)

_____ ____/____/____
Initials Date

_____
Comments

_____ ____/____/____
Initials Date

_____
Comments

_____ ____/____/____
Initials Date

_____
Comments

Signature_____ Date_____/_____/_____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse