INSURANCE VERIFICATION

Patient:_____ DOB:_____

Subscriber:_____ Member ID: _____

Subscriber DOB: _____ Effect. Date: _____ Calendar/Fiscal

Insured Employer_____ Group # _____

Insurance Company: _____ Phone #: _____

Mailing Address: _____

Maximum_____/_____ Deductible: _____Y/N Waiting Period: Y/N Missing Tooth: Y/N

Preventive: _____ Basic:_____ Major:_____ Perio: _____ Endo: _____ Ortho: ____ O.S.:_____

BWX: 1 or 2 yr/Hist: _____ Pan/FMX: 3 or 5 yr/Hist: _____ D0140:_____ D0150: _____

Exams: 1 or 2 yr/Hist: _____Prophy: 1 or 2 yr/Hist: _____ Implants: _____/____Freq. _____

Sealants up to: _____/_____Freq. %: _____ Perm. Molars Y/N

Fluoride up to: _____/_____Freq. %: _____D9940 Occlusal Guard: _____/_____%

SRP (4341/4342): _____% all quads in 1 day Y/N 1/24 months **Charting/Narrative/Xrays**

FMD (4355) : _____% Once in a lifetime Y/N Hist: _____Crown Replacement Period_____

Perio Maintenance (4910): _____% Freq.: _____Alternate Benefits Y/N

Ins Rep: _____Verified by: _____Date: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	_____
Are you on a special diet?	Yes	No	Women: Are you
Do you use tobacco?	Yes	No	Pregnant/Trying to get pregnant? Nursing?
Do you use controlled substances?	Yes	No	Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Hypoglycemia	Rheumatic Fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Irregular Heartbeat	Rheumatism
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Kidney Problems	Scarlet Fever
Anemia	Convulsions	Hay Fever	Leukemia	Shingles
Angina	Cortisone Medicine	Heart Attack/Failure	Liver Disease	Sickle Cell Disease
Arthritis/Gout	Diabetes	Heart Murmur	Low Blood Pressure	Sinus Trouble
Artificial Heart Valve	Drug Addiction	Heart Pacemaker	Lung Disease	Spina Bifida
Artificial Joint	Easily Winded	Heart Trouble/Disease	Mitral Valve Prolapse	Stomach/Intestinal Disease
Asthma	Emphysema	Hemophilia	Osteoporosis	Stroke
Blood Disease	Epilepsy or Seizures	Hepatitis A	Pain in Jaw Joints	Swelling of Limbs
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Parathyroid Disease	Thyroid Disease
Breathing Problem	Excessive Thirst	Herpes	Psychiatric Care	Tonsillitis
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Radiation Treatments	Tuberculosis
Cancer	Frequent Cough	High Cholesterol	Recent Weight Loss	Tumors or Growths
Chemotherapy	Frequent Diarrhea	Hives or Rash	Renal Dialysis	Ulcers
				Venereal Disease
				Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____