



**PATIENT HEALTH RECORD**  
(Please Print)

*A and A Dental*  
Alan P. Gross DDS

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)

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