Welcome

"Your personal dental care is our highest priority"

advanced DENTAL WELLNESS

Mark D. Raisch, D.D.S.
Gregory S. Beers, D.D.S.
4501 N. High St.
Columbus, OH 43214
614.267.5413

Patient Information

Name:_____ Today's Date:_____

Birthdate:_____ Age:_____ Sex: M_____ F_____ Social Security Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Home phone: (_____)_____-_____ Cell phone: (_____)_____-_____ Work phone: (_____)_____-_____

Email:_____ Employer:_____

Email Communication: Yes_____ No_____ **Text Message Communication**: Yes_____ No_____

Married: _____ Partnered: _____ Divorced:_____ Single: _____ Minor: _____

Emergency Contact: _____ Relationship:_____ Phone:(_____)_____-_____

Whom may we thank for referring you?_____

Responsible Party

same as above:_____

Person Responsible for Account: _____ Relationship to patient:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Birthdate: _____ Social Security Number: _____ Employer: _____

Home phone: (_____)_____-_____ Cell phone: (_____)_____-_____ Work phone: (_____)_____-_____

Insurance Information

Name of Subscriber:_____ Relationship to patient:_____

Subscriber Address:_____ City:_____ Zip Code:_____

Birthdate:_____ Social Security number:_____ Employer:_____

INSURANCE COMPANY:_____ Group#_____

Insurance Company Address:_____

Additional Insurance (Secondary)

Name of Subscriber: _____ Relationship to patient: _____

Birthdate:_____ Social Security number:_____ Employer:_____

INSURANCE COMPANY:_____ Group#_____

Insurance Company Address:_____

Medical History

Have you ever been hospitalized or had a major operation?_____ If yes, describe_____

Are you taking any medications, pills or drugs?_____ Please list:_____

Do you have Osteoporosis?_____ Do you currently take a bone replacement drug?_____ Have you in the past?_____

Are you allergic to any of the following? ___Aspirin ___Penicillin ___Sulfa ___Codeine

___Acrylic ___Metal ___Latex ___Local Anesthetics ___Other, please specify:_____

Do you use tobacco?____ If yes, what type, how many times a day, for how many years?_____

WOMEN: Are you… Pregnant or trying to get pregnant ___yes ___no

Nursing ___yes ___no Taking oral contraceptives ___yes ___no

Check () if you have or have had any of the following:

___AIDS/HIV positive
___Alzheimer's Disease
___Anaphylaxis
___Anemia
___Anxiety
___Angina
___Arthritis/Gout
___Artificial Heart Valve
___Artificial Joint
___Asthma
___Blood Disease
___Blood Transfusion
___Breathing Problems
___Cancer
___Chemotherapy
___Chest Pains
___Cold Sores/Fever Blisters
___Congenital Heart Disorder
___Convulsions
___Cortisone Medicine
___Diabetes
___Drug Addition
___Easily Winded
___Emphysema
___Epilepsy or Seizures
___Excessive Bleeding
___Excessive Thirst
___Fainting Spells/Dizziness
___Frequent Cough
___Frequent Diarrhea
___Frequent Headaches
___Genital Herpes
___Glaucoma
___Hay Fever
___Heart Attack/Failure
___Heart Murmur
___Heart Pacemaker
___Heart Trouble/Disease
___Hemophilia
___Hepatitis A
___Hepatitis B or C
___Herpes
___High Blood Pressure
___High Cholesterol
___Hives or Rash
___Hypoglycemia
___Irregular Heartbeat
___Kidney Problems
___Leukemia
___Liver Disease
___Low Blood Pressure
___Lung Disease
___Mitral Valve Prolapse
___Pain in Jaw Joints
___Parathyroid Disease
___Psychiatric Care
___Radiation Treatments
___Recent Weight Loss
___Renal Dialysis
___Rheumatic Fever
___Rheumatism
___Scarlet Fever
___Shingles
___Sickle Cell Disease
___Sinus Trouble
___Spina Bifida
___Stomach/Intestinal Disease
___Stroke
___Swelling of Limbs
___Thyroid Disease
___Tonsillitis
___Tuberculosis
___Tumors or Growths
___Ulcers

Dental History

Reason for today's visit _____ Date of last dental cleaning & exam _____

Previous dentist _____ Date of last dental x-rays _____

Address _____ Phone_____

Check (✓) if you have had or currently have problems with any of the following:

___Bad breath ___Grinding teeth ___Sensitivity to hot

___Bleeding gums ___Loose teeth or broken fillings ___Sensitivity to sweets

___Clicking, popping or pain w/jaw ___Periodontal treatment ___Sensitivity when biting/chewing

___Food collection between teeth ___Sores or growths in mouth ___Sensitivity to cold

How often do you floss?_____ How often do you brush?_____

Would you be interested in any of the following?

___Whitening ___Correcting crowding/spacing ___Electric toothbrush

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Mark Raisch, Dr. Gregory Beers or any associate of Advanced Dental Wellness, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature_____ Date_____

Print name_____