



Raymond M Hubrich DDS, PC
Cosmetic and General Dentistry

About You

Email address: _____
First Name: _____
Middle Name: _____
Last Name: _____
Suffix: Mr. Mrs. Ms. Dr.
I prefer to be called: _____
Gender: Male Female
Birthdate: _____ Age: _____
Social Security #: _____

Home Address

Street: _____
City: _____ State: ____ Zip: _____
Marital Status Married Single Divorced Widowed
Home Phone #: _____
Work Phone #: _____ Ext: _____
Driver's License: _____
Employer: _____

Employer's Address

Street: _____
City: _____ State: _____ Zip: _____
How long there? _____ Occupation: _____
Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____
Previous / Present Dentist: _____
Person Responsible for account: _____
Spouse Information
His / Her Name: _____
Employer: _____
Work Phone #: _____ Ext: _____
Social Security #: _____
Birthdate: _____
Driver's License: _____
Relative or Friend not living with you His / Her Name: _____
Relation: _____
Home phone #: _____

Work phone #: _____

Insurance

Primary Insurance

Dental coverage: yes no

Insurance Co. _____

Name: _____

Insurance Co. _____

Address: _____

Insurance Co. Phone

#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____

Insured's ID#: _____

Insured's Employer: _____

Employer's address: _____

Secondary Insurance

Dental coverage: yes no

Insurance Co. _____

Name: _____

Insurance Co. _____

Address: _____

Insurance Co. Phone

#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birth date: _____

Insured's ID#: _____

Insured's Employer: _____

Employer's address: _____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature

Date

MEDICAL HISTORY

Do you have a personal physician? yes no

Physician's Name: _____

Phone #: _____

Date of Last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician: yes no

Please explain:

Do you smoke or use tobacco in any other form? yes no

Have you had any metal rods, pins or implants? yes no

Are you taking any prescription / over-the-counter drugs? yes no

Please list all prescription/over the counter or herbal supplement drugs that you are currently taking:

Have you ever taken Phen-Fen? Also known as Redux or Pondimin. yes no

If so, when? _____

FOR WOMEN:

Are you using a prescribed method of birth control? yes no

Are you pregnant? yes no

Are you nursing? yes no

HAVE YOU EVER HAS ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS:

- | | | | |
|-----------------------------------|--|-----------------------------|--|
| Abnormal Bleeding /Hemophilia | <input type="radio"/> yes <input type="radio"/> no | High Blood Pressure | <input type="radio"/> yes <input type="radio"/> no |
| AIDS | <input type="radio"/> yes <input type="radio"/> no | HIV | <input type="radio"/> yes <input type="radio"/> no |
| Alcohol / Drug Abuse | <input type="radio"/> yes <input type="radio"/> no | Hospitalized for any reason | <input type="radio"/> yes <input type="radio"/> no |
| Anemia | <input type="radio"/> yes <input type="radio"/> no | Kidney Problems | <input type="radio"/> yes <input type="radio"/> no |
| Arthritis | <input type="radio"/> yes <input type="radio"/> no | Liver Disease | <input type="radio"/> yes <input type="radio"/> no |
| Artificial Bones / Joints /Valves | <input type="radio"/> yes <input type="radio"/> no | Low Blood Pressure | <input type="radio"/> yes <input type="radio"/> no |
| Asthma yes no | <input type="radio"/> yes <input type="radio"/> no | Blood Transfusion | <input type="radio"/> yes <input type="radio"/> no |
| Lupus | <input type="radio"/> yes <input type="radio"/> no | Cancer / | <input type="radio"/> yes <input type="radio"/> no |
| Mitral Valve Prolapse | <input type="radio"/> yes <input type="radio"/> no | Chemotherapy | |

- | | | | |
|-------------------------|--|------------------------------|--|
| Pacemaker | <input type="radio"/> yes <input type="radio"/> no | Psychiatric Problems | <input type="radio"/> yes <input type="radio"/> no |
| Congenital Heart Defect | <input type="radio"/> yes <input type="radio"/> no | Radiation Treatment | <input type="radio"/> yes <input type="radio"/> no |
| Diabetes | <input type="radio"/> yes <input type="radio"/> no | Rheumatic / Scarlet Fever | <input type="radio"/> yes <input type="radio"/> no |
| Difficulty Breathing | <input type="radio"/> yes <input type="radio"/> no | Seizures | <input type="radio"/> yes <input type="radio"/> no |
| Emphysema | <input type="radio"/> yes <input type="radio"/> no | Shingles | <input type="radio"/> yes <input type="radio"/> no |
| Epilepsy | <input type="radio"/> yes <input type="radio"/> no | Sickle Cell Disease / Traits | <input type="radio"/> yes <input type="radio"/> no |
| Fainting Spells | <input type="radio"/> yes <input type="radio"/> no | Sinus Problems | <input type="radio"/> yes <input type="radio"/> no |
| Glaucoma | <input type="radio"/> yes <input type="radio"/> no | Stroke | <input type="radio"/> yes <input type="radio"/> no |
| Hay Fever | <input type="radio"/> yes <input type="radio"/> no | Thyroid Problems | <input type="radio"/> yes <input type="radio"/> no |
| Heart Attack / surgery | <input type="radio"/> yes <input type="radio"/> no | Tuberculosis (TB) | <input type="radio"/> yes <input type="radio"/> no |
| Heart Murmur | <input type="radio"/> yes <input type="radio"/> no | Ulcers | <input type="radio"/> yes <input type="radio"/> no |
| Hepatitis | <input type="radio"/> yes <input type="radio"/> no | Venereal Disease | <input type="radio"/> yes <input type="radio"/> no |
| Herpes / Fever Blisters | <input type="radio"/> yes <input type="radio"/> no | Colitis | <input type="radio"/> yes <input type="radio"/> no |

Please list any serious medical condition (s) that you have ever had:

Are you allergic to any of the following?

Aspirin <input type="radio"/> yes <input type="radio"/> no	Latex <input type="radio"/> yes <input type="radio"/> no
Codeine <input type="radio"/> yes <input type="radio"/> no	Penicillin <input type="radio"/> yes <input type="radio"/> no
Erythromycin <input type="radio"/> yes <input type="radio"/> no	Tetracycline <input type="radio"/> yes <input type="radio"/> no
Jewelry/Metals <input type="radio"/> yes <input type="radio"/> no	Other <input type="radio"/> yes <input type="radio"/> no
Dental Anesthetics <input type="radio"/> yes <input type="radio"/> no	

Please list any other drugs / materials that you are allergic to:

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? yes no

Do you require antibiotics before dental treatments? yes no

Your current dental health is: good fair poor

Have you ever had a serious/difficult problem associated with any previous dental work? yes no

Do you floss daily? yes no

Type of bristles on your toothbrush? hard medium soft

Have you ever had gum treatment? yes no

Do your gums ever bleed? yes no

Do your gums ever itch? yes no

Have you ever had periodontal disease? yes no

