



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 yes no

Bleeding  
/Hemophilia

AIDS yes no

Alcohol / Drug yes no

Abuse

Anemia yes no

Arthritis yes no

Artificial Bones / yes no

Joints /Valves

Asthma yes no yes no

Lupus yes no

Mitral Valve yes no

Prolapse

High Blood Pressure yes no

HIV yes no

Hospitalized for any yes no

reason

Kidney Problems yes no

Liver Disease yes no

Low Blood Pressure yes no

Blood Transfusion yes no

Cancer / yes 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

Have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? yes no  
Do you have any loose teeth? yes no  
Do you still have wisdom teeth? yes no  
Would you like fresher breath? yes no  
Whiter teeth? yes no  
Are you happy with the way your smile looks? yes no

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

---

Signature

Date

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

OFFICE USE ONLY

OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

---

Doctor Signature

Date