Robert F. Sonntag, D.D.S.

ABOUT YOU:

Full Legal Name _____ I prefer to be called _____

Home Address _____ City _____ State _____ Zip _____

☐ Male ☐ Female Birthdate _____ Age _____ SS # _____

☐ Single ☐ Married ☐ Divorced ☐ Separated Driver's License # _____

Home/Cell Phone _____ Work Phone _____ ext. _____ Email _____

Employer _____

Employer Address _____

How long there _____ Occupation _____

Previous dentist _____ Last visit date _____

Person responsible for account _____

_____

Please list other family members we have seen _____

Who may we thank for referring you? _____

ABOUT YOUR SPOUSE *(if applicable)*

Name _____

Employer _____

Work Phone _____ ext. _____ Pager / Other _____

Birthdate _____ Drivers License # _____ SS # _____

PRIMARY DENTAL INSURANCE

Insurance Co. name _____

Address _____

Phone # _____ Group plan or policy # _____

Policy holder's name _____ Policy holder's birthday _____

Policy holder's S.S .# _____ Policy holder's employer _____

SECONDARY DENTAL INSURANCE

Insurance Co. name _____

Address _____

Phone # _____ Group plan or policy # _____

Policy holder's name _____ Policy holder's birthday _____

Policy holder's S.S. # _____ Policy holder's employer _____

see other side

GENERAL INFORMATION

Are you currently under the care of a physician? ☐ Yes ☐ No *If yes, please explain:* _____

Have you had any recent operations - Please list:_____

Are you taking any prescription/over-the counter drugs? ☐ Yes ☐ No *If yes, please list:* _____

_____

FOR WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No Week # _____ Are you currently nursing? ☐ Yes ☐ No

PLEASE CHECK – YES OR NO

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

Make sure you answer each individually, all items must be checked with a Yes or No.

Heart Murmur ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No
Heart Attack/Stroke (circle) ☐ Yes ☐ No
Heart Surgery/Pacemaker (circle) ☐ Yes ☐ No
Congenital Heart Defect ☐ Yes ☐ No
Heart Valve Replacement ☐ Yes ☐ No
Bone or Joint Replacement ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Diabetes/Tuberculosis (circle) ☐ Yes ☐ No
Kidney Problems ☐ Yes ☐ No
Epilepsy/Seizures/Fainting Spells ☐ Yes ☐ No
Hemophilia/Abnormal Bleeding ☐ Yes ☐ No
Cancer/Chemotherapy/Radiation (Circle) ☐ Yes ☐ No
Ulcers/Colitis (Circle) ☐ Yes ☐ No

Severe/Frequent Headaches ☐ Yes ☐ No
High/ Low Blood Pressure (Circle) ☐ Yes ☐ No
Shingles ☐ Yes ☐ No
HIV+/AIDS ☐ Yes ☐ No
Aspirin/ Blood Thinners (Circle) ☐ Yes ☐ No
Sinus Problems ☐ Yes ☐ No
Fever Blisters ☐ Yes ☐ No
Psychiatric Problems ☐ Yes ☐ No
Drug/Alcohol Abuse ☐ Yes ☐ No
Anemia/Radiation Treatment ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Difficulty Breathing/ Emphysema (Circle) ☐ Yes ☐ No
Hospitalized For Any Reason ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?

Penicillin ☐ Yes ☐ No
Aspirin ☐ Yes ☐ No
Dental Anesthetics ☐ Yes ☐ No
Codeine ☐ Yes ☐ No

Tetracyline ☐ Yes ☐ No
Latex ☐ Yes ☐ No
Erythromycin ☐ Yes ☐ No
Other ☐ Yes ☐ No

Please list any other drugs you are allergic to: _____

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 this office of any changes in my medical status. I authorize the dental staff to perform with my informed consent, any necessary dental services I may need during diagnosis and treatment. Payment is due in full at the time of treatment. I understand I am responsible for payment regardless of insurance coverage.

Signature _____ Date _____