PATIENT INFORMATION

PATIENT NAME: _____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female
LAST FIRST MIDDLE

Preferred Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ SSN _____
MO DAY YEAR

Telephone (Mobile) _____ (Work) _____ (Home) _____

If Rogue Dental is unable to reach you, at which number(s) may we leave a detailed message? Home Cell Work Other_____

Would you like to receive text reminders? ☐ YES ☐ NO Email correspondence? ☐ YES ☐ NO

Email _____ Employer: _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group # _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name: _____ First: _____ Initial: ____

Address *(if different)* _____ City _____ State _____ Zip _____

Date of Birth _____ SSN _____ Email _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

EMERGENCY CONTACT OUTSIDE OF HOUSEHOLD

Last Name: _____ First: _____ Initial: ____

Telephone (☐ Mobile ☐ Work ☐ Home) _____

AUTHORIZATION AND RELEASE

1. I consent to the diagnostic procedures, including x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by my dentist to make a thorough diagnosis of my (or my child's) dental needs.
2. I further authorize my dentist to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that my dentist may choose and employ such assistance as deemed fit to provide recommended treatment.
3. I consent to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist or specialist, or for evaluating and administering any claims for insurance benefits.
4. I AUTHORIZE THE ASSIGNMENT OF MY INSURANCE BENEFITS TO RICHARD LEONG D.D.S. I understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance
5. ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications as indicated in my preferences above. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time.

Signature _____ Date _____

(I attest to the accuracy of the information on this page. Responsible Party, if under 18)

HEALTH HISTORY

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Physician's Name_____Phone No._____

   Address_____
4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication, drugs or pills? ..... YES NO

   If yes, please list:_____
6. Are you aware of being allergic or have you ever reacted adversely to any medication or substance? ..... YES NO

   If yes, please list:_____
7. Are you aware of being allergic or have you ever reacted adversely to latex, vinyl or rubber? ..... YES NO
8. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	Cold Sores/Fever Blisters	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Blood Transfusion	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Hemophilia	YES	NO
Arteriosclerosis	YES	NO	Cosmetic Surgery	YES	NO	Anemia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Sickle Cell Disease	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Bruise Easily	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Liver Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Yellow Jaundice	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Epilepsy or Seizures	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Fainting or Dizzy Spells	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Nervousness	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Psychiatric Treatment	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Developmentally Disabled	YES	NO
Stroke	YES	NO	Hepatitis A (infectious)	YES	NO			

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
10. Do your ankles swell during the day? ..... YES NO
11. Do you use more than two pillows to sleep? ..... YES NO
12. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
13. Do you ever wake up from sleep and feel short of breath ..... YES NO
14. Are you on a special diet ..... YES NO
15. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
16. Are you pregnant? ..... YES NO
17. Do you have or have you had any disease, condition, or problem not listed ..... YES NO

    *If yes, please list*_____

    _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

Dr. Evaluation _____ Date _____

Comment _____

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_____