Welcome

Gina Prokosh-Cook, D.D.S. – Family Dentistry

Patient Information

Date _____

Patient _____

Social Security Number _____

Address _____

City_____

State _____ Zip _____

E-mail _____

Sex M F Date of Birth _____ Age____

Occupation_____

Patient Employer/School _____

Employer/School Address _____

_____

_____

Employer/School Phone_____

Married Widowed Single Minor

Separated Divorced Partnered

Referred by _____

Phone Numbers

Home _____ Work _____ Cell Phone _____

Best time and place to reach you _____

In Case of Emergency

Name_____ Phone Number_____

Relationship_____ Cell Phone _____

Dental Insurance

Who is responsible for this account _____

Relationship to patient _____

PRIMARY INSURANCE

Dental Insurance Company_____

Address _____

Subscriber's Name _____

Relationship to patient _____

Birthdate _____

Social Security Number _____

Group Number_____

SECONDARY INSURANCE

Dental Insurance Company_____

Address _____

Subscriber's Name _____

Relationship to patient _____

Birthdate _____

Social Security Number _____

Group Number_____

Assignment and Release

Guardian Subscribers

I certify that I, and/or my dependent(s), have insurance coverage with Guardian and assign directly to **Dr. Gina Prokosch-Cook**, 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.

_____

Signature of Patient/Parent/Guardian Date

All Other Insurance Subscribers

I certify that I, and/or my dependent(s), have insurance coverage with a plan that Dr. Cook is not a participant in. l agree to pay Dr. Cook for all services rendered at the time of visit. Insurance forms will be provided by Dr. Cook as a convenience. I understand that these forms can be submitted for my reimbursement.

_____

Signature of Patient/Parent/Guardian Date

Dental History

Reason for today's visit_____
Former Dentist_____
City/State_____
Date of Last Dental Visit_____
Date of Last Dental Xrays_____
How often do you brush? _____
How often do you floss? _____

Do you need antibiotics before dental treatment? **YES○ NO○**
Condition _____
Treating Physician _____
Address_____
Phone Number_____

Bleeding/Swollen gums	__ Yes __ No
Blisters on lips or mouth	__ Yes __ No
Burning sensation on tongue	__ Yes __ No
Cigarette, pipe or cigar smoking	__ Yes __ No
Dry mouth	__ Yes __ No
Grinding teeth	__ Yes __ No
Jaw pain/popping	__ Yes __ No
Loose teeth/Broken fillings	__ Yes __ No
Orthodontic Treatment	__ Yes __ No
Pain around ear	__ Yes __ No
Periodontal Treatment	__ Yes __ No
Sensitivity to hot / cold / sweets	__ Yes __ No
Sores or growths in mouth	__ Yes __ No

Medical Health History

Primary Care Physician _____ Phone_____

AIDS/HIV	__ Yes __ No
Anemia	__ Yes __ No
Arthritis	__ Yes __ No
Asthma	__ Yes __ No
Artificial Joints	__ Yes __ No
What Joint _____	
Year Placed _____	
Artificial Heart Valve	__ Yes __ No
Back Problems	__ Yes __ No
Bleeding Abnormally With extractions or surgery	__ Yes __ No
Blood Disease	__ Yes __ No
Cancer	__ Yes __ No
Chemical Dependency	__ Yes __ No
Chemotherapy	__ Yes __ No
Circulatory Problems	__ Yes __ No
Congenital Heart Lesion	__ Yes __ No
Cortisone Treatment	__ Yes __ No
Diabetes	__ Yes __ No
Emphysema	__ Yes __ No
Epilepsy	__ Yes __ No
Heart Murmur	__ Yes __ No
Hepatitis Type __	__ Yes __ No
High Blood Pressure	__ Yes __ No
Radiation Treatment	__ Yes __ No
Respiratory Disease	__ Yes __ No
Rheumatic Fever	__ Yes __ No
Scarlet Fever	__ Yes __ No
Sinus Trouble	__ Yes __ No
Stroke	__ Yes __ No
Swollen Neck Glands	__ Yes __ No
Thyroid Problems	__ Yes __ No
Tonsillitis	__ Yes __ No
Tuberculosis	__ Yes __ No
Tumor on head /neck	__ Yes __ No

Women
Are you pregnant? __ Yes __ No
due date _____
Taking birth control pills __ Yes __ No
Are you nursing__ Yes __ No

Medications

List any medications you are currently taking, the dosage and correlating diagnosis

_____
_____
_____
_____
_____
_____

Are you currently taking blood thinners? __ Yes __ No

Have you had any recent surgeries? __ Yes __ No

Allergies

__ Aspirin/ Ibuprofen
__ Codeine
__ Gluten
__ Local Anesthetic
__ Latex
__ Penicillin
__ Sulfa
__ Other Medicine Allergy
_____
__ Other Food/Dye Allergy
_____
__ Other Allergy
_____

Notice of Privacy Practices

I acknowledge that I have that I have read and understood the Privacy Practices of Dr. Gina Prokosh-Cook and authorize the use of my health information accordingly

Name _____ Relationship to patient _____

Signature _____ Date _____