CONFIDENTIAL PATIENT INFORMATION

Tim K. Gossweiler, DDS
14904 Greyhound Court
Carmel, IN 46032

PLEASE PRINT OR WRITE LEGIBLY

DATE:_____/____/_____

PATIENT INFORMATION

Name: _____ S.S.#:_____
Address: _____
Telephone: Home: _____ Business: _____
Birthdate: _____ Sex: _____ Marital Status _____ Spouse Name: _____
Occupation: _____ Referred by: _____
Employer: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____S.S.#: _____
Address: _____
Home Phone: _____ Work Phone: _____
Employer: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co.: _____
NAME INS. CO. PHONE #

_____
STREET CITY STATE ZIP
Employee: _____ Birthdate: _____ Relationship: _____
S.S. #: _____ Employer: _____
Policy Number: _____
Secondary Insurance Co.: _____
NAME INS. CO. PHONE #

_____
STREET CITY STATE ZIP
Employee: _____ Birthdate: _____ Relationship: _____
S.S. #: _____ Employer: _____
Policy Number: _____

PERSON TO BE CONTACTED IN EMERGENCY
NAME ADDRESS PHONE #

HEALTH INFORMATION

Personal Physician:_____
NAME ADDRESS PHONE

PLEASE CHECK YES OR NO FOR EACH QUESTION	YES	NO
1. Have you been hospitalized within the past 2 years? For what?		
2. Are you currently being treated by a physician? For what?		
3. Are you currently taking any medicines or drugs? What?		
4. Do you smoke or use any tobacco products? How long?		
5. Are you allergic to any drugs? What?		
6. Are you allergic to any metals? What?		
7. Have you ever had a skin rash or other reaction to metal jewelry? To what?		
8. Do you bleed excessively upon injury?		
9. Are you pregnant?		
10. When was your last dental visit? What was done?		

CHECK ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD		
☐ Arthritis	☐ Heart Problems	☐ Nervous Breakdown or Psych. Treatment
☐ Asthma/Respiration Problems	☐ Heart Murmur	☐ Radiation Treatment
☐ Blood Transfusion	☐ Hepatitis	☐ Rheumatic Fever
☐ Cancer	☐ High or Low Blood Pressure	☐ Sexually Transmitted Diseases
☐ Diabetes	☐ HIV/AIDS	☐ Stroke
☐ Drug/Alcohol Abuse	☐ Jaundice	☐ Tuberculosis
☐ Epilepsy	☐ Joint Replacements	☐ Other diseases (please list)
☐ Glaucoma	☐ Kidney Problems	

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

X_____

Signature of patient or parent if minor