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 Telephone ______________ Work Telephone ______________ ext. ________

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 Telephone ______________ ext. ______ Pager / Other ______________

Birthdate ____________ Drivers License # ______________ SS # ______________

PRIMARY DENTAL INSURANCE

Insurance Co. name ____

Address ____

Telephone # ______________________ 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 ____

Telephone # ______________________ 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.

Condition	Yes	No	Condition	Yes	No
Heart Murmur	☐ Yes	☐ No	Severe/Frequent Headaches	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	High/Low Blood Pressure (circle)	☐ Yes	☐ No
Heart Attack/Stroke (circle)	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Heart Surgery/Pacemaker (circle)	☐ Yes	☐ No	HIV+/AIDS	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No	Aspirin/Blood Thinners (circle)	☐ Yes	☐ No
Heart Valve Replacement	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Bone or Joint Replacement	☐ Yes	☐ No	Fever Blisters	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Psychiatric Problems	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Drug/Alcohol Abuse	☐ Yes	☐ No
Diabetes/Tuberculosis (circle)	☐ Yes	☐ No	Anemia/Radiation Treatment	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Epilepsy/Seizures/Fainting Spells	☐ Yes	☐ No	Difficulty Breathing/Emphysema (circle)	☐ Yes	☐ No
Hemophilia/Abnormal Bleeding	☐ Yes	☐ No	Hospitalized For Any Reason	☐ Yes	☐ No
Cancer/Chemotherapy/Radiation	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Ulcers/Colitis (circle)	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?

Drug	Yes	No	Drug	Yes	No
Penicillin	☐ Yes	☐ No	Tetracyline	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Latex	☐ Yes	☐ No
Dental Anesthetics	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No
Codeine	☐ 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 ____________