ERIC T. MONG, DDS
FAMILY DENTISTRY

724.588.8910
408 S. Main St. | Greenville, PA 16125

1. ABOUT YOU

Today's Date: _____/_____/_____ File #:_____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ☐ Male ☐ Female

Birthdate: _____/_____/_____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: (_____) _____ Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____ E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How Many?_____

2. INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____ Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: _____/_____/_____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____ Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: _____/_____/_____

Insured's Employer: _____

3. ACCOUNT INFO

Person ultimately responsible for account

Name: _____ Relation: _____

Billing Address: _____

_____

CITY STATE ZIP

SS #:_____ Drivers License #: _____

Work Phone #: (_____) _____

Payment Method: ☐ Cash ☐ Check ☐ Credit Card – Enter card # below (if accepted)

_____ _____/_____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

INITIALS

4. IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____ Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____

Who is your Medical Doctor: _____

Medical Doctor's Phone #: (_____) _____

5. DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes How Long? _____

Please indicate any of the following problems:

☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth

☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Locking Jaw

☐ Sensitive tooth , teeth or gums. ☐ Ringing in Ears ☐ Bad breath

☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth

☐ Other: _____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don 't know

Previous Dentist: _____ (_____) _____

NAME PHONE #

Last Dental exam: _____/_____/_____ Last Dental X-rays: _____/_____/_____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

6. MEDICAL HISTORY

What medications are you taking?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers
☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers
☐ Insulin ☐ Meds for Osteoporosis ☐ Other(s), please list:

_____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No Phen-fen/Redux ☐ Yes ☐ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin
☐ Dental Anesthetics ☐ Foods:_____ ☐ Others: _____
Do you use tobacco? ☐ No ☐ Yes/How used? _____How much?_____ How long? _____
Please rate your general health from 1-10: _____ Do you wear contact lenses? ☐ Yes ☐ No
For women: Are you taking Birth Control pills? ☐ Yes ☐ No How many children have you had? _____
Are you pregnant? ☐ No ☐ Yes/How long? _____ Are you nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
INITIALS

Signature _____ Date: _____/_____/_____
☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

OFFICE USE ONLY

Dentist's Signature: _____