

Michael R. Boldt, D.M.D.

Patient Information

Patient's Name _____
Last First Middles

Name I prefer to be called _____ Birthday _____

Address _____
Street City State Zip

Home _____ Work Phone _____ E-mail _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Have you or any member of your family been seen in this office before? Yes No

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middles Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middles

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative or friend not living with you _____

Complete Address _____

Phone _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, NOT TO EXCEED THE CHARGES SHOW. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS INSURANCE AUTHORIZATION. AFTER 60 DAYS A FINANCE CHARGE OF 1.5% PER MONTH, WHICH IS AN ANNUAL PERCENTAGE RATE OF 18%, IS APPLIED TO THE UNPAID BALANCE. TERMS: NET 30 DAYS - INTEREST CHARGED ON PAST DUE ACCOUNTS. I AUTHORIZE RELEASE OF ANY INFORMATION RELATED TO THIS CLAIM; I UNDERSTAND THAT, WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

DATE

SIGNATURE

MICHAEL R. BOLDT, D.M.D.
Health Questionnaire
 For your health's sake you must be accurate

Name _____ Date of Birth _____ Sex M F

Physicians Name _____ Physicians Phone Number _____

Answers to the following questions are for our records only and will be considered confidential. Please answer all questions by marking the appropriate box.

- _____
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Are you having any pain or discomfort at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you dissatisfied with the appearance of your teeth or smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel very nervous about receiving dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had a bad experience in the dental office? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you been a patient in the hospital during the past two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you been under care of a physician during the past two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you taking any medications at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| if so, what? _____ | | |

8. Have you ever had excessive bleeding requiring special treatment?

9. Are you allergic to, or had an unusual reaction to any of the following medications:

	Yes	No		Yes	No
Dental Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

10. Please mark any of the following which you have had or have at this time:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Injury to face or jaw |
| <input type="checkbox"/> Heart disease or attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> AIDS or HIV positive |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Radiation or cobalt treatment | <input type="checkbox"/> Hepatitis A (infectious) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Chemotherapy (cancer) | <input type="checkbox"/> Hepatitis B (serum) |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow jaundice |
| <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Cortisone medicine | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pain in Jaw Joint | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Difficulty opening mouth wide | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Sinus troubles | <input type="checkbox"/> Difficulty chewing food | <input type="checkbox"/> Epilepsy or seizure |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Allergies or hives | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Fainting or dizziness |
| <input type="checkbox"/> Drug or alcohol abuse | <input type="checkbox"/> Excessive nervousness | | <input type="checkbox"/> Bruise easily |

11. Do you use any type of tobacco at this time?

12. 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?

13. Do your ankles swell during the day?

14. Have you lost or gained more than 10 lbs. in the past year?

15. Are you on a special diet?

16. Has your physician ever said you have cancer or a tumor?

17. Do you have any other disease, condition or problem not listed?

18. WOMEN: Are you pregnant now?

 Do you anticipate becoming pregnant?

To the best of my knowledge all the preceding answers are true and correct.

DATE

SIGNATURE OF PATIENT, PARENT OR GUARDIAN