Rob E. Sable, DDS PC
Patient Information Forms

(* = ***Required fields)***

Patient Full Name*_____ Preferred Name _____

Date of Birth*_____ Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐ Widowed

Home Address* _____

City* _____ State* _____ Zip* _____

Telephone (Home)* _____ (Office) _____ (Cell)*_____

SSN_____-_____-_____ Email*_____

How Did You Hear About Us? If Referred, by Whom?

_____

Is Another Member of Your Family or a Relative in Our Practice? ☐ YES ☐ NO

Name _____ Relationship _____

Emergency

Who Would You Like Us to Contact FIRST in Case of an Emergency?* _____

Relationship to Patient _____

Home Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Office) _____ (Cell) _____

Financial

Who is Financially Responsible for the Payment of Your Account**?*** _____

Relationship to Patient _____ Phone Number, if Different from Patient _____

Home Address _____

City _____ State _____ Zip _____

PAYMENT IN FULL IS DUE AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.
We will submit your insurance claim for you. However, we do not accept assignment.

Insurance Information

Insurance Co. Name_____ Group # _____

Insurance Co. Customer Service Phone _____

Insurance Co. Address _____

Home Address _____

City _____ State _____ Zip _____

Subscriber's Name _____Relation _____

Subscriber's Date of Birth_____ Subscriber's SSN _____-_____-_____

Subscriber's Employer_____

The information that I have given is true and correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence. I hereby authorize the doctor or designated staff to take x-rays, study models, bacteriological cultures, diagnostic casts, photographs, biopsies of oral tissue, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the above name patient's dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand that I am responsible for the total fee for the services rendered.

Patient/Parent/Guardian Signature*_____Date*_____

PATIENT HEALTH HISTORY

Recent research indicates a strong relationship between the mouth and body. We are going to be asking you some questions about your family history and your overall health that we may not have asked you about before.

Name*_____

Telephone (Home)* _____ (Office) _____ (Cell)* _____

Email*_____

Are You Under the Care of Physician? ☐ YES ☐ NO

Primary Care Physician_____

Have You Had Any Serious Illnesses or Operations in the Last 5 Years? ☐ YES ☐ NO

Describe_____

Have You Ever Had a Blood Transfusion? ☐YES ☐NO If yes, When? _____

Are You on a Blood Thinner? ☐ YES ☐ NO

Are You Pregnant? ☐ YES ☐ NO Are You Nursing? ☐ YES ☐ NO Are You Taking birth controls pills? ☐YES ☐ NO

Check if You Currently Have or Have a History of the Following:

☐Artificial Hip or Knee Joint If Yes, Premed? ☐ YES ☐ NO

☐Heart Murmur If Yes, Premed? ☐ YES ☐ NO

☐Rheumatic Fever If Yes, Premed? ☐ YES ☐ NO

☐Diabetes Type_____ ☐Hepatitis Type_____

☐Alcohol Abuse ☐Congenital Heart Disease ☐Kidney Disease/Stones

☐Drug Abuse ☐COPD ☐Mitral Valve Prolapse

☐Anemia ☐Nervous/Anxious ☐Pacemaker

☐Arthritis ☐Epilepsy/Seizures ☐Sinus

☐Artificial Heart Valve ☐Glaucoma ☐Stroke

☐Asthma ☐Heart Attack/Cardiac Issues ☐Thyroid

☐Bruise Easily ☐HIGH/LOW blood pressure ☐Tuberculosis

☐Cancer ☐HIV/AIDS ☐Ulcers

☐Chemotherapy/Radiation ☐Hypoglycemia ☐Venereal Disease

☐Other_____

Check if You Are Allergic To or Have Reacted Adversely to Any of the Following:

☐Aspirin ☐Codeine/Other Narcotics ☐Latex

☐Barbiturates (Sleeping Pills) ☐Iodine ☐Local Anesthetics

Antibiotics:

☐Penicillin ☐Erythromycin

☐Sulfa ☐ Tetracycline

☐Other:_____

Check if You are Having Problems with Any of the Following:

☐Bleeding Gums ☐Grinding Teeth ☐Sensitivity to Hot or Cold

☐Clicking or Popping Jaw ☐Jaw Pain ☐Sensitivity When Chewing

☐Dry Mouth ☐Mouth Breathing ☐Sores or Growths in Your Mouth

☐Food Collection between Teeth ☐Periodontal Disease

Gum disease has been linked with an increased risk for many chronic diseases. Eliminating gum disease is especially important to the oral and overall health.

☐Tobacco User

Tobacco users are more likely to develop gum disease which is more severe and more difficult to eradicate.
Gum disease itself has recently been linked with an increased risk for heart disease. Since tobacco users are already at an increased risk for heart disease, and gum disease only worsens the risk, it is vitally important for tobacco users to do whatever is necessary to eliminate gum disease.

Current Tobacco User? ☐ YES ☐ NO What Form (Cig, Pipe, Chew, etc.)_____
Previous Tobacco User? ☐ YES ☐ NO When Did You Quit?_____

☐Diabetes

Diabetes is well –known risk factor for gum disease. Research is confirming that when left untreated gum disease makes it harder for you to control your blood sugar. Elimination of gum disease can improve your blood sugar control reducing your risk for the serious complications.

How is your diabetes control? ☐Good ☐Fair ☐Poor

☐Family History of Gum Disease

Some people are genetically prone to developing gum disease even if they take excellent care of their mouths.

Do you have any family history of gum disease? ☐YES ☐NO ☐Don't Know

☐Stress

Stress is a well-known risk factor for gum disease. Is your stress level too high? ☐YES ☐NO

Life altering events (loss of job, divorce, death in family, moving to new location, etc) can be particularly strong factors for gum disease. Are you currently going through and life altering events? ☐YES ☐NO

☐Rheumatoid Arthritis

There is a bi-directional connection between rheumatoid arthritis. If you have arthritis you are at an increased risk for gum disease. Emerging research suggests that eliminating any gum disease and then keeping it at bay can lessen the crippling effects of arthritis.

CURENT MEDICATIONS AND DOSAGES

Medications	Purpose	Dose	How Long?

Other Comments

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