robert b.
CHURNEY dmd
healthy gums for healthy lives.

Date:_____

Patient Information

Patient Name _____ SS #_____

If minor, Parent/Guardian Name _____

Address _____ Email_____

City _____ State_____ Zip_____

Home Phone _____ Cell Phone_____ Office_____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Employer/School_____ Occupation_____

Spouse_____ Employer_____

Whom may we thank for referring you_____

In case of emergency who should be notified? _____ Phone _____

Primary Dental Insurance

Cardholder Name _____

Relation to Patient _____ Birthdate _____ SS# _____

Address (if different from patient's)_____ Phone_____

City _____ State _____ Zip _____

Cardholder Employed by _____

Insurance Company _____ Phone_____

Insurance Company Address _____

Subscriber/ID # _____ Group # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Churney all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my heath care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is competed or one year from the date signed below.

_____ _____

Signature date

_____ _____

Please print name of Patient, Guardian or Personal Representative Relation to Patient

28469 US 19 North, Suite 401, Clearwater, FL 33761
{web} churneyperio.com {email} info@churneyperio.com {phone} 727-799-6733 {fax} 727-726-9157

Over ⇨

Dental History

Reason for Today's Visit _____

Check (✓) if you have had problems with any of the following

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or popping jaw
☐ Food Collection between teeth
☐ Grinding teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth

Medical History

Physician's Name _____Phone_____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe_____

_____

Do you or have you in the past taken bisphosphonates (Fosomax, Boniva)? ☐ Yes ☐ No

Do you pre-medicate for dental procedures? ☐ Yes ☐ No Are you on Blood Thinners (Coumadin, Plavix)? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease

Medications

List medications you are currently taking:

_____

_____

Pharmacy Name_____

Phone (_____)_____

Allergies

☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Local Anesthetic
☐ Penicillin or other antibiotics
☐ Sulfa
☐ Latex
☐ Other_____
_____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____