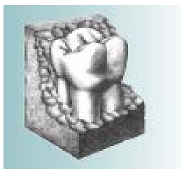

Patient Information

(Confidential)

Dale D. Batten, DMD, PA
Comprehensive Dentistry

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, don't hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ______________________________ SS# __________
First Middle Last

Address: ______________ City ________ State ____ Zip ____

Sex: ☐ Female ☐ Male Birth date: ________ E-mail: ______________

Home Phone ( ) ________ Cell Phone ( ) ________ Work Phone ( ) ________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partnered for ___ years

Patient Employer / School ______________ Occupation ______________

Employers / School Address ______________ City ________ State ____ Zip ____

Spouse/Parent Name ______________ Employer ______________

Who may we thank for referring you to us? ______________

Person to contact in case of emergency: ______________ Phone ( ) ________

Responsible Party

Name of person responsible for this account ______________

Relationship to patient ______________ Phone ( ) ________

Address ______________ City ________ State ____ Zip ____

Name of Employer ______________ Work Phone ( ) ________

Dental Insurance Information

Name of Insured ______________ Relationship to patient ________

Birth date ________ Social Security # ________ Date Employed ________

Name of Employer ______________ Work Phone ( ) ________

Address ______________ City ________ State ____ Zip ____

Insurance Co. ________ Group # ________ Employer # ________

Insurance Co. Address ________ City ________ State ____ Zip ____

How much is your deductible? ____ Benefits used YTD ____ Max Annual Benefit ____

DO YOU HAVE ADDITONAL INSURANCE? ☐ No ☐ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured ______________ Relationship to patient ________

Insured Birthdate ________ Social Security # ________ Date Employed ________

Name of Employer ________ Work Phone ( ) ________

Address ______________

City ________ State ________ Zip ________

Insurance Co. ______________ Group # ________

Insurance Co Address ______________ Employer # ________

City ________ State ________ Zip ________

How much is your deductible? ____ Benefits used YTD ____ Max Annual Benefit ____

Dental History

Dale D. Batten, DMD, PA
Comprehensive Dentistry

Name ______________________ Age ________ Date of last exam ______________

Previous Dentist ______________________ Date of last Dental X -Ray ______________

What is your immediate concern? ______________________________

How often do you brush? ______________ How often do you floss? ______________

How often do you get your teeth cleaned? 3 Mo. ☐ 4 Mo. ☐ 6 Mo. ☐ 1 Yr or longer ☐

Do you have dental implants? ______________ How long have you had them? ______________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO	Comments
1. Unhappy with the appearance of your teeth	☐	☐	
2. Unfavorable dental experience	☐	☐	
3. Dental fears	☐	☐	
4. Problems with effectiveness or bad reaction to dental anesthetic	☐	☐	
5 Orthodontic treatment (braces) when:	☐	☐	
6. Periodontal (gum) treatment when:	☐	☐	
7. Food collection between teeth	☐	☐	
8. Bleeding gums	☐	☐	
9. Avoid brushing any part of your mouth	☐	☐	
10. Part of your mouth is sensitive to temperature	☐	☐	
11. Sore teeth	☐	☐	
12. A burning sensation in your mouth	☐	☐	
13. Difficulty swallowing	☐	☐	
14. An unpleasant taste in your mouth	☐	☐	
15. Dry mouth, throat, and or eyes	☐	☐	
16. Jaw problems (tempromandibular joint)	☐	☐	
17. Difficulty opening your mouth widely	☐	☐	
18. Stiff neck muscles	☐	☐	
19. Awakened with an awareness of your teeth or jaws	☐	☐	
20. Tension headaches	☐	☐	
21. Clench or grind your teeth	☐	☐	
22. Jaw clicking or popping	☐	☐	

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing removable complete or partial dentures, please complete the following:

Yes	No	(Please check Yes or No)
☐	☐	Has your present denture been relined? When? ______________
☐	☐	Is your present denture a problem? Describe: ______________
☐	☐	Satisfied with the appearance? ______________
☐	☐	Satisfied with the comfort? ______________
☐	☐	Satisfied with the chewing ability? ______________

When did you receive your first partial or complete denture? ______________

How long have you worn your present denture? ______________

Patient Signature ______________________ Date: ______________

Doctors Signature ______________________ Date: ______________

Remarks: ______________________________

Medical History

Dale D. Batten, DMD, PA
Comprehensive Dentistry

Patient's Name: ______________________________ Age: ______________

Please list all medications you are currently taking: ______________________________

Allergies: Penicillin ☐ Aspirin ☐ Local Anesthetic ☐ Latex ☐ Metals ☐ Sulfa ☐ Codeine ☐ Other ☐

Please list any other allergies: ______________________________

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

What is the estimate of your general health? Poor ☐ Fair ☐ Good ☐

Physician Name____________________ Physician #______________________

Please check if you have had any of the following:

Y / N		Y / N		Y / N		Y / N	
☐ ☐	AIDS	☐ ☐	Congenital Heart Lesion	☐ ☐	Hepatitis (type___)	☐ ☐	Rheumatic Fever
☐ ☐	Anemia	☐ ☐	Cortisone Treatments	☐ ☐	Hernia Repair	☐ ☐	Scarlet Fever
☐ ☐	Arthritis, Rheumatism	☐ ☐	Cough, Persistent	☐ ☐	High Blood Pressure	☐ ☐	Shortness of Breath
☐ ☐	Artificial Heart Valve	☐ ☐	Cough up Blood	☐ ☐	HIV Positive	☐ ☐	Skin Rash
☐ ☐	Artificial Joints	☐ ☐	Diabetes	☐ ☐	Jaw Pain	☐ ☐	Stroke
☐ ☐	Asthma	☐ ☐	Epilepsy	☐ ☐	Kidney Disease	☐ ☐	Swelling of feet / Ankle
☐ ☐	Back Problems	☐ ☐	Fainting	☐ ☐	Liver Disease	☐ ☐	Thyroid Problems
☐ ☐	Bleeding Abnormally	☐ ☐	Glaucoma	☐ ☐	Mitral Valve Prolapse	☐ ☐	Tobacco habits
☐ ☐	Blood Disease	☐ ☐	Headaches	☐ ☐	Nervous Problems	☐ ☐	Tonsillitis
☐ ☐	Cancer	☐ ☐	Heart Murmur	☐ ☐	Pacemaker	☐ ☐	Tuberculosis
☐ ☐	Chemical Dependency	☐ ☐	Heart Problems	☐ ☐	Psychiatric Care	☐ ☐	Ulcers
☐ ☐	Chemotherapy	Describe:	______________	☐ ☐	Radiation Treatment	☐ ☐	Venereal Disease
☐ ☐	Circulatory Problems	☐ ☐	Hemophilia	☐ ☐	Respiratory Disease	☐ ☐	Drugalcohol dependency

Have you ever taken any of these medications?

Biophosphonates/	☐ Actonel	☐ Fosamax	☐ Bonivia	☐ Aredia
(for osteoporosis)	☐ Bonefox	☐ Didronel	☐ Zometa	☐ other
Blood Thinners:	☐ Coumadin	☐ Warfarin		

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

____

____

Certification, Assignment and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that if I and/or my dependant(s), have insurance coverage, I assign directly to Dale D. Batten, DMD, PA all insurance benefits, if any, and otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.
The above named doctor may use my healthcare 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 payable for related services or referring doctors offices.
In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policies. .
I consent to the making of videotapes, photographs and x-rays before during and after treatment, and to the use of same by the doctor in scientific papers, marketing or demonstrations.
I certify that I have read or had this read to me the contents of this form and do realize the risks and limitations.

Signature:______________________________Date:__________

(Patient, Parent, Guardian or Personal Representative)

Patient Information

(Confidential)

Dale D. Batten, DMD, PA
Comprehensive Dentistry

Patient Name __________________________ DOB:____________

Acknowledgement of Receipt of Privacy Practices:

I acknowledge that I have received/read a copy of the officers Notice of Privacy Practices.

Patient Sign: ____

Date _________________________

HIPPA Privacy Authorization Form

I hereby authorize Drs. Batten and Manzoli and/or their staff to discuss my healthcare issues with the following person(s):

Name: ________________________________

Relationship:___________________________________

Name: ________________________________

Relationship:___________________________________

I understand I have the right to revoke this authorization.

Patient Sign:____

Date ____________________________