Welcome

Robert J. Gorhum, DDS

Patients Name_____ Date of Birth_____

Mailing/Street Address_____

City_____ State_____Zip_____

Driver's License #_____ SS#_____Cell Phone Number_____

Home Phone Number_____ Employer Phone Number_____

Place of Employment _____ Address_____

Emergency Family Contact_____Number_____

RESPONSIBLE PARTY (Parent):

Name of Responsible Party_____Date of Birth_____

Relationship to Patient_____

Mailing Address_____ Phone #_____

Place of Employment_____Work #_____

Employment Address_____State_____Zip_____

Driver's License #_____ Social Security # _____

DENTAL INSURANCE:.

Name of Insured_____ Date of Birth_____Telephone_____

Address_____Social Security #_____

Name of Company_____Telephone #_#_____

Mailing Address_____State_____Zip_____

Policy #_____ Group #_____

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MEDICAL HISTORY:

Name of Physician_____

Address_____State_____ZIP_____

Telephone Number_____

Date of Last Visit_____Reason For Visit_____

Currently Taking any Drugs or Medical Treatment? ___No ___Yes Please List Med._____

_____

**** ARE YOU ALLERGIC TO ANY MEDICINE** (LIST)_____

PLEASE CHECK <u>ONLY</u> THOSE AREAS THAT APPLIED TO YOUR HEALTH:

_____ Heart Trouble/Chest Pain
_____ Mitral Valve Prolapse
_____ Blood Pressure
_____ Heart Murmur/Valve Replacement
_____ Stroke
_____ Diabetes/Hypoglycenia
_____ Rheumatic/Scarlet Fever
_____ Frequent Headaches
_____ Cancer: Type_____
_____ Hepatitis: Type_____
_____ Liver Disease
_____ Kidney/Dialysis
_____ Asthma
_____ Breathing Problems/Empysema
_____ Lung Disease
_____ Tuberculosis (TB)

_____ Thyroid
_____ S T D
_____ Herpes
_____ HIV/AIDS
_____ Stomach Disease/Ulcers
_____ Acid Reflux
_____ Leukemia
_____ Hemophilia
_____Arthritis
_____ Lupus E.
_____ Sickle Cell Disease
_____ Convulsions/Epilepsy
_____ Alzheimer's Disease
_____ Autoimmune System Defencies
_____ Abnormal Bleeding/Anemia
_____Lupus E.

____ Gastro-Intestinal/Colon
____ Smoke/Alchol Drinker
____ Osteoporosis Medication
____ Hearing Impairment
____ Rheumatism
____ Joint/Neck Pain
____ Head/Neck/Back Injury
____ Prosthetic Limbs/Joints
____ Handicap/Disabilities
____ Pregnant
____ Surgery

Any Other Problems:_____

Has a Doctor advised you to take antibotics before having dental treatment?_____

Date Of Last Visit to a Dentist_____

Do You Grind or Clench Teeth at Night_____No_____Yes

Would you be interested in a simple way to whiten your teeth ?_____

What Concerns You Most About Your Oral Health?_____

What Changes Would You Like to See About Your Smile or Bite?_____

Does Anyone Snore in Your Household? _____

What Sports do you participate in?_____

Signature:_____Date_____

REQUEST FOR RELEASE OF HEALTH INFORMATION

I,_____,Hereby Give My Consent For

_____
(Print Name of Doctor or Hospital)

To Release Information Related To My Health History, Status, And Treatment, And Copies

of My Health Records, X-Rays, and Any Test Results To: Robert J.Gorhum, DDS
310 South Oak
Pearsall, Texas 78061
830-334-4181

Signature_____Date_____

If Minor, Patient or Guardian Must Sign:
Print Name:_____Date_____

INSURANCE ASSIGNMENT OF BENEFITS

I Hereby Authorize Payment of The Dental Benefits Otherwise Payable to Me Directly To The

Below Named Dental Entity: Robert J. Gorhum, DDS
310 South Oak
Pearsall, Texas 78061
830-334-4181

I Authorize Release of Any Information Relating To This Claim. I Understand That I Am Responsible

For All Costs of Dental Treatment.

Signature_____

Print Name_____Date_____

Acknowledgement Of Receipt
of
Notice of Privacy Practices

I, _____ have received a copy of

Pearsall Dental, Robert J. Gorhum, DDS Notice of Privacy Practices.

_____

(Signature of Patient)

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reasons:

_____Patient refused to sign.

_____Emergency situation kept us from obtaining the patient's signature.

_____Language barriers kept us from obtaining the patient's signature.

_____Other_____