

# WELCOME TO OUR PRACTICE!

Please take a few moments to answer the following questions so we can better assist you with your dental needs.

## Thomas C. Volck, D.D.S.

General Dentist providing Cosmetic and Family Care

270 James E. Bohanan Memorial Dr.

Vandalia, OH 45377

p. 937.898.8990

f. 937.898.3298

### Patient Information

Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Name \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Sex:  Male  Female  Minor  Single  Married Spouse's Name \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Whom should we thank for referring you? \_\_\_\_\_

In case of emergency, who should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

### Dental Insurance

>>>Please present your insurance card to the receptionist if you prefer to have our office submit your claims.<<<

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Responsible Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

### Dental History

Date of Last Dental Visit \_\_\_\_\_

Date of Last X-Rays \_\_\_\_\_

Please check all that apply:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad Breath                | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets              |
| <input type="checkbox"/> Bleeding Gums             | <input type="checkbox"/> Orthodontic Treatment (Braces) | <input type="checkbox"/> Sensitivity When Biting            |
| <input type="checkbox"/> Blisters on Lips or Mouth | <input type="checkbox"/> Pain Around Ear                | <input type="checkbox"/> Frequent Headaches                 |
| <input type="checkbox"/> Finger Nail Biting        | <input type="checkbox"/> Periodontal Treatment          | <input type="checkbox"/> Jaw, Head or Neck Injuries         |
| <input type="checkbox"/> Grinding Teeth            | <input type="checkbox"/> Sensitivity to Cold            | <input type="checkbox"/> Jaw Difficulty: Clicking &/or Pain |
| <input type="checkbox"/> Lip or Cheek Biting       | <input type="checkbox"/> Sensitivity to Heat            | <input type="checkbox"/> Tooth Pain                         |

**(Please complete on reverse side)**

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**Medical History**

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Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Cardiologist's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Current Medical Treatment: \_\_\_\_\_

Serious illness or operations: \_\_\_\_\_

Please list **medications** you are taking AND the **conditions** for which you are receiving them:\_\_\_\_\_  
\_\_\_\_\_Yes No

- Do you smoke?  
  Do you use cocaine or other drugs?

**Have you had any allergic reactions to any of the following:**Yes No

- Local anesthetics (e.g. Novocain)  
  Penicillin or other antibiotics  
  Sulfa Drugs  
  Barbiturates (sleeping pills)

Yes No

- Sedatives  
  Iodine  
  Aspirin  
  Other: \_\_\_\_\_

**Have you ever taken bisphosphonates (fosamax)?**Yes No

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**REVIEWED HEALTH HISTORY:**

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**Women only, are you:**Yes No

- Pregnant?  
  Nursing?  
  Taking birth control pills?

**Please check all that apply:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS  | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Pacemaker                 |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Psychiatric Care          |
| <input type="checkbox"/> Arthritis, Rheumatism                               | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Radiation Treatment       |
| <input type="checkbox"/> Artificial Heart Valves                             | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Respiratory Disease       |
| <input type="checkbox"/> Artificial Joints                                   | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Back Problems                                       | <input type="checkbox"/> Heart Problems        | <input type="checkbox"/> Shortness of Breath       |
| <input type="checkbox"/> Bleeding Abnormally, with<br>extractions or surgery | <input type="checkbox"/> Hepatitis-Type _____  | <input type="checkbox"/> Sinus Trouble             |
| <input type="checkbox"/> Blood Disease                                       | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Skin Rash                 |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Chemical Dependency                                 | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Swelling of Feet/Ankles   |
| <input type="checkbox"/> Chemotherapy  | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Swollen Neck Glands       |
| <input type="checkbox"/> Chronic Fatigue Syndrome                            | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Circulatory Problems                                | <input type="checkbox"/> Latex Sensitivity     | <input type="checkbox"/> Tonsillitis               |
| <input type="checkbox"/> Congenital Heart Lesions                            | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Cortisone Treatments                                | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tumor/growth on head/neck |
| <input type="checkbox"/> Cough-persistent or bloody                          | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Ulcer                     |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease          |
|  | <input type="checkbox"/> Nervous Problems      |  |

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**Authorization**

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I hereby authorize payment directly to Thomas C. Volck, D.D.S. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I agree to pay co-payments or self-payments at time of service.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Witness: \_\_\_\_\_