Durand Dental

117 S. Center St., Durand, IL 61024
(815) 248-2124

Welcome *– Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.*

PATIENT INFORMATION

Name_____ Birthdate_____ SS#_____ Phone_____

Address_____ City_____ State_____ Zip_____

Employer_____ Work Phone_____

Business Address_____ City_____ State_____ Zip_____

Spouse's Name_____ Employer_____ Work Phone_____

If Patient is a Student, Name of School/College_____ City_____ State_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of Emergency_____ Phone_____

RESPONSIBLE PARTY

Person Responsible for this Account_____ Relation to Patient_____

Address_____ City_____ State_____ Zip_____

Phone_____ Birthdate_____ SS#_____ Driver's License #_____

Employer_____ Work Phone_____

Currently a Patient in our Office? ____Yes ____No

PRIMARY INSURANCE

Name of Insured_____ Relation to Patient_____

Birthdate_____ Social Security #_____ Date Employed_____

Employer_____ Work Phone_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Union/Local #_____

Address_____ City_____ State_____ Zip_____

How Much is Your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit_____

SECONDARY INSURANCE

Name of Insured_____ Relation to Patient_____

Birthdate_____ Social Security #_____ Date Employed_____

Employer_____ Work Phone_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Union/Local #_____

Address_____ City_____ State_____ Zip_____

How Much is Your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit_____

DENTAL HISTORY

Reason for today's visit_____

Former Dentist_____

Address_____ City_____ State_____ Zip_____

Date of last dental visit_____ Date of last dental X-rays_____

Check if you have had any of the following:

___ Bad Breath
___ Bleeding
___ Clicking or popping jaw
___ Food collection between the teeth
___ Grinding teeth
___ Loose teeth or broken fillings
___ Periodontal treatment
___ Sensitivity to cold
___ Sensitivity to heat
___ Sensitivity to sweets
___ Sensitivity when biting
___ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____ Date of last visit_____

Have you had any serious illnesses or operations? ___ Yes ___ No If yes, describe_____

Have you ever had a blood transfusion? ___ Yes ___ No If yes, give approximate dates_____

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

Check if you have had any of the following:

___ AIDS
___ 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 Murmer
___ Heart Problems
Describe_____
___ Hemophilia
___ Hepatitis
___ High Blood Pressure
___ HIV Positive
___ Jaw Pain
___ Kidney Disease
___ Liver Disease
___ Mitral Valve Prolapse
___ Nervous Problems
___ Pacemaker
___ Psychiatric Care
___ Radiation Treatment
___ Respiratory Disease
___ Rheumatic Fever
___ Scarlet Fever
___ Shortness of Breath
___ Skin Rash
___ Stroke
___ Swelling Feet/Ankles
___ Thyroid Problems
___ Tobacco Habit
___ Tonsillitis
___ Tuberculosis
___ Ulcer
___ Venereal Disease

MEDICATIONS

List Medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to Dr. Hambel benefits otherwise payable to me. I authorize Dr. Hambel to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for **ALL** fees regardless of insurance coverage. Should I default, I agree to pay all costs of collection, including, but not limited to, collection agency fees, court costs, and reasonable attorney's fees.

_____ _____

Signature of patient or parent if minor Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

24-HOUR NOTICE NECESSARY FOR APPOINTMENT CANCELLATION