Cuthrell DDS & Mochnick DMD
1341-B Westgate Center Drive • Winston Salem, NC 27103 • 336.765.3712

Patient Information

Name_____SSN_____DOB_____
Street Address_____
City_____State_____Zip Code_____ ☐ Male ☐ Female
Home #_____Work#_____Cell#_____
Email Address _____☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Employer_____ Occupation_____
Emergency Contact_____ Relationship_____ Phone #_____
Whom may we thank for referring you to our practice?_____

Dental Insurance Information

Please provide the following dental insurance information.

Name of Insured_____
Relationship to Patient_____
Subscriber DOB_____
Subscriber ID/SSN_____
Subscriber Employer_____
Group #_____
Insurance Company_____
Phone Number_____

Financial Policy

We are happy to file a claim and accept payment from your insurance company, although we are not in network. However, there is no guarantee of payment from your carrier, even though we have verified your coverage.

YOU, THE INSURED ARE ULTIMATELY RESPONSIBLE FOR THE FEES INCURRED FOR YOUR DENTAL CARE.

Please understand that should any of the following occur, you will be held responsible for the entire amount due:

1) Payment has not been received from insurance company within 45 days of filed claim.
2) Payment is denied by the insurance company.
3) A balance remains after the insurance payment.

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill or services. I have read the financial policy on this form and agree to be responsible for payment of all services rendered to myself and my dependents.

Signature of Patient, Parent or Guardian **Date**

Medical History

Primary Physician_____ Phone #_____

1. Are you having pain or discomfort at this time? ☐ YES ☐ NO
2. Do you feel very nervous about having dental treatment? ☐ YES ☐ NO
3. Have you ever had a bad experience in the dental office? ☐ YES ☐ NO
4. Have you been a patient in the hospital during the past two years? ☐ YES ☐ NO
5. Have you been under the care of a medical doctor during the past two years? ☐ YES ☐ NO
6. Have you taken any medicine or drugs during the past two years? (List below) ☐ YES ☐ NO

MEDICATIONS:_____

_____

7. Have you ever been required to take a pre-med before dental treatment? ☐ YES ☐ NO
8. Have you ever had any excessive bleeding requiring special treatment? ☐ YES ☐ NO
9. Are you allergic to any drugs or medications? If so, list them here ☐ YES ☐ NO

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10. Check any of the following which you have had or have at present.

☐ AIDS	☐ Diabetes	☐ Hemophilia	☐ Pregnant/Nursing
☐ Allergies/Hives	☐ Drug/Alcohol Abuse	☐ Hepatitis A	☐ Pre-medication required
☐ Anemia	☐ Emphysema	☐ Hepatitis B	☐ Psychiatric treatment
☐ Angina	☐ Epilepsy/Seizures	☐ Hepatitis C	☐ Rheumatic Fever
☐ Arthritis	☐ Fainting/Dizziness	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Glaucoma	☐ High Cholesterol	☐ Sinus Trouble
☐ Artificial Joint	☐ Hay Fever	☐ HIV	☐ STD
☐ Asthma	☐ Heart Attack	☐ Kidney Disease	☐ Stroke
☐ Blood Transfusion	☐ Heart Disease	☐ Liver Disease	☐ Thyroid Disease
☐ Bronchitis	☐ Heart Failure	☐ Mitral Valve Prolapse	☐ Tobacco Use
☐ Chemotherapy/Radiation	☐ Heart Murmur	☐ Nervousness	☐ Tuberculosis
☐ Cold Sores	☐ Heart Surgery	☐ Pain in jaw joint	☐ Ulcers

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest? ☐ YES ☐ NO
12. Have you lost or gained more than ten pounds during the past year? ☐ YES ☐ NO
13 . Do you have any disease or condition not listed? ☐ YES ☐ NO
14. **Women:** Are you pregnant or nursing? ☐ YES ☐ NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist at the next appointment, without fail.

Signature of Patient, Parent or Guardian **Date**