



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 _____ Subscriber Employer _____
 Relationship to Patient _____ Group # _____
 Subscriber DOB _____ Insurance Company _____
 Subscriber ID/SSN _____ 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:

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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.

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