GREGG E. UECKERT, DDS

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Patient Information

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ (Last) ____________ (First) ____ (MI) ____________ (Preferred Name)

Title: ________ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________

SS#: ___-__-____

Prev. Visit: ____________

Email Address: ____________ **Best time to call:** ____________

Phone: ________ (Home) ________ (Mobile) ________ (Work) ____ (Ext) ________ (Fax) ________ (Other)

Address: ____________ (Address 1) ____________ (Address 2)

____________ (City) ____ (State) _____-____ (Zip Code)

Do you have or have you had any of the following diseases or conditions?

☐ Alcohol/Drug Treat	☐ Allergy Aspirin	☐ Allergy Augmentin	☐ Allergy Cephalexin
☐ Allergy Codeine	☐ Allergy Codeine	☐ Allergy Demoral	☐ Allergy Doxacycline
☐ Allergy Erythromycin	☐ Allergy Ibuprofen	☐ Allergy Latex	☐ Allergy Local Anesth
☐ Allergy Other	☐ Allergy Penicillin	☐ Allergy Sulfa	☐ Allergy Tetracycline
☐ Allergy Vicodin	☐ Anemia	☐ Angina	☐ Antidepressants
☐ Arthritis	☐ Artificial Joints	☐ Asthma	☐ Blind
☐ Bruises easily	☐ Cancer	☐ Chemo/Radiation	☐ COVID-19
☐ Dental Anxiety	☐ Diabetes	☐ Digestive Condition	☐ Dizziness
☐ Eating Disorder	☐ Epilepsy/Seizure	☐ Excessive Bleeding	☐ Gagger
☐ Glaucoma	☐ Head Injuries	☐ Hearing Impaired	☐ Heart Condition
☐ Heart Mumur	☐ Hepatitis	☐ High Blood Pressure	☐ HIV
☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure	☐ Med w/ Blood Thinner
☐ Medicate w/ Dilantin	☐ MS	☐ Novocaine	☐ Osteoporosis
☐ Pacemaker	☐ Parkinsons	☐ Penicillin	☐ Psychiatric Care
☐ Require PRE-MED	☐ Respiratory problem	☐ Rheumatic Fever	☐ Rheumatism
☐ Sens to EPI	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Synthroid	☐ Thyroid Condition	☐ Tuberculosis	☐ Ulcers
☐ Venereal Disease/STD			

List Drug or Medicines you are presently taking:

____

____

____

____

Do you have any health problems that need further clarification?

Please give the name of your Medical Physician & phone number:

____

____

EMERGENCY CONTACT & PHONE NUMBER:

____

____

DENTAL HISTORY

Are your teeth sensitive to:

☐ HEAT ☐ COLD ☐ SWEETS ☐ BITING PRESSURE

Do you have Dental Anxiety? ○ Yes ○ No

Do you get cold sores or fever blisters? ○ Yes ○ No

Do your gums bleed when brushing? ○ Yes ○ No

Have you ever had gum surgery? ○ Yes ○ No

Do you clench or grind your teeth? ○ Yes ○ No

Does your jaw click or pop when opening? ○ Yes ○ No

Do you experience pain at base of skull? ○ Yes ○ No

Do you suffer from tension or migraine headaches? ○ Yes ○ No

Have you ever been treated for TMJ problems? ○ Yes ○ No

Have you ever had braces? ○ Yes ○ No

Do you smoke? ○ Yes ○ No

Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips? ○ Yes ○ No

How long has it been since your last cleaning and complete exam? ____________________

Who may we thank for referring you to our practice?

____

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: ____________

ID #: ________________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: ____________

ID #: ______________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to contact me by email or telephone to discuss my treatment.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Response Date: ___________

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NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM

Patient Name: ______________________ ______________________ ___ ______________

Last First MI Preferred Name

The notice sent to you via email describes how medical information about you may be used and disclosed and how you can get access to this information. Review the policy carefully and let us know if you have any questions or requests.

☐ ***I acknowledge that I have received the Notice of Health Information Practices of Dr. Gregg Ueckert. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke the consent in writing, except to the extent that the organization has already taken action in reliance thereon.**

Response Date: __________