LAURI BARGE, D.D.S.

Family, Restorative, and Cosmetic Dentistry

3380 Long Prairie Road, Suite 200; Flower Mound, TX 75022

phone:972-539-3800 fax:972-539-2215

Patient Information

Date:____________ Home Phone: ___________________ Work Phone:___________________Cell:___________________

Name:____ Social Security Number: _______- ________- ______

Address: ____City: _____________ State: ______ Zip: _______________

Sex: M☐ F☐ Birthdate:____________________________ ☐Minor ☐Single ☐Married ☐Widowed ☐Divorced

Patient Employed By: _______________________________ Email Address: _____________________________________

Whom may we thank for referring you: ____

In case of emergency who should be notified: _______________________________________ Phone: ________________

Responsible Party

Name of person responsible for the account: ____Phone:______________

Address of responsible party: ________________________________City: ____________ State: ______ Zip: __________

Relationship to the patient: ___________________________ Birthdate:_______________ SSN: ______ ______ ______

Dental Insurance Information

Name of the Insured:____Relationship to Patient: ____________________

Insured's Date of Birth: ____________________ SSN: ______- ______- ______ Employer: ________________________

Insurance Company: ____ Phone: ___________________________

Group Number: _____________________________________ Employee/Cert. Number: ____________________________

Insurance Company Address: _________________________________City: ____________ State: ______ Zip: ________

Deductible: ______________ Amount Already Used: _________________ Maximum Annual Benefit: _________________

Do you have Secondary Insurance Coverage: Yes ☐ No ☐ If yes, please complete the following information:

Name of Insured: ___________________________________ Relationship to Patient: ______________________________

Insured's Date of Birth: ____________________ SSN: ______- ______- ______ Employer: ________________________

Insurance Company: ____ Phone: _____________________________

Group Number: _____________________________________ Employee/Cert. Number: ____________________________

Insurance Company Address: _________________________________City: ____________ State: ______ Zip: ________

Deductible: ______________ Amount Already Used: _________________ Maximum Annual Benefit: _________________

I authorize the Dr. Barge 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 dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Barge. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signed:____

Patient Information

I, the patient, (parent or guardian), have made a contract with my insurance company to provide for third party reimbursement for my dental care. As the patient, (parent or guardian), I understand that I am responsible for understanding and complying with my insurance benefits, limitations, and exclusions and will be financially responsible for complying with my insurance benefits, limitations, and exclusions. I understand that I am financially responsible for any non-covered charge I also understand and agree to pay any remaining balance following insurance payment. If for any reason my account with Dr. Barge is placed with a collection agency, I will be responsible for any fees which are added to the debt due to the collection process. I also agree to pay a $25 convenience fee for any returned checks.

I, the patient, agree to arrive on time for my appointment. I understand that this time is reserved especially for my benefit. I understand that without 24 hours notice of a cancellation, I will compensate Dr. Barge at $50/hour for time lost on my account.

Signature of Patient or Legal Guardian:_______________________________________

Dental History

Name: ______________________________

Reason for today's visit: ______________________________

When was your last dental visit: ______________________________

How often do you brush your teeth: ______________________________

What texture toothbrush do you use: Soft ☐ Medium ☐ Hard☐

•*Please circle an answer for* ***each question*** *listed below:*

Question		
Do you feel pain to any of your teeth when brushing or flossing them:	YES	NO
Do your gums bleed while brushing:	YES	NO
Do your gums bleed when flossing:	YES	NO
Are your teeth sensitive to hot, cold, sweet or sour foods or liquids:	YES	NO
Have you noticed any loosening of your teeth:	YES	NO
Does food tend to become caught between your teeth:	YES	NO
Do you have any sores or lumps in or near your mouth:	YES	NO
Have you ever experienced any of the following problems in your jaw:		
Clicking:	YES	NO
Pain (joint, ear, side of face):	YES	NO
Difficulty opening/closing:	YES	NO
Have you had any head, neck, or jaw injuries:	YES	NO
Do you have frequent headaches:	YES	NO
Do you clench or grind your teeth:	YES	NO
Do you bite your lips or cheeks frequently:	YES	NO
Have you ever had:		
Orthodontic treatment (Braces):	YES	NO
Oral surgery:	YES	NO
Your teeth ground or the bite adjusted:	YES	NO
Worn a bite plate or other appliance:	YES	NO
Are you satisfied with the appearance of your teeth:	YES	NO
Have you ever had an upsetting experience in the dental office:	YES	NO
Is there anything about having dental treatment that bothers you:______________________	YES	NO

Medical History

Question		
Are you in good health:	YES	NO
Have there been any changes in your general health within the past year:____________________	YES	NO
When was your last physical exam:____________________		
Physician's Name:______________________________		
Address:______________________________		
Telephone: ______________________________		
Are you now under the care of a physician:	YES	NO
Have you ever been hospitalized for any surgical operation or serious illness: If yes, please explain:______________________________	YES	NO
Are you currently taking any medication(s) including nonprescription medicine(s): If yes, list here:______________________________	YES	NO
Have you had a recent weight loss:	YES	NO
Are you currently taking any diet pills or herbs: If yes, list here:______________________________	YES	NO
Have you ever taken Phen Fen:	YES	NO
Have you had any abnormal bleeding:	YES	NO
Do you bruise easily:	YES	NO
Have you ever required a blood transfusion:	YES	NO
Do you use tobacco:	YES	NO
Do you use alcohol:	YES	NO
Do you use cocaine or other drugs:	YES	NO
Are you wearing contact lenses:	YES	NO
Do you have any disease, condition, or problem not listed above that you think I should know about:______________________	YES	NO
Are you allergic to or have you had reactions to:		
Local anesthetics like novocaine:	YES	NO
Penicillin:	YES	NO
Sulfa Drugs:	YES	NO
Barbiturates, Sedatives or Sleeping Pills:	YES	NO
Aspirin:	YES	NO
Iodine:	YES	NO
Latex:	YES	NO
Other Antibiotics: ______________________________		
Other Allergies: ______________________________		

Medical History Continued . . .

Do you have, or have you ever had, any of the following:

Condition		
Rheumatic heart disease or rheumatic fever	YES	NO
Scarlet Fever	YES	NO
Heart defect or heart murmur	YES	NO
Heart trouble, heart attack, or angina	YES	NO
Do you have pain in your chest upon exertion	YES	NO
Are you ever short of breath after mild exercise	YES	NO
Do your ankles swell	YES	NO
Do you get short of breath when you lie down	YES	NO
Do you require extra pillows when you sleep	YES	NO
Pacemaker	YES	NO
Heart Surgery	YES	NO
High Blood Pressure	YES	NO
Low Blood Pressure	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Liver Disease	YES	NO
Stroke	YES	NO
Lung or Breathing Problems	YES	NO
Asthma	YES	NO
Hay Fever	YES	NO
Hives or Skin Rash	YES	NO
Fainting Spells or Seizures	YES	NO
Diabetes	YES	NO
AIDS or HIV Infection	YES	NO
Sinus Trouble	YES	NO
Thyroid Problems	YES	NO
Allergies	YES	NO
Arthritis or Rheumatism	YES	NO
Joint Replacement or Implant	YES	NO
Stomach Ulcer	YES	NO
Kidney Trouble	YES	NO
Tuberculosis	YES	NO
Persistent Cough	YES	NO
Cough that produces blood	YES	NO
Cancer	YES	NO
Sexually Transmitted Disease	YES	NO
Epilepsy	YES	NO
Anemia	YES	NO
Leukemia	YES	NO
Glaucoma	YES	NO
Eating Disorder	YES	NO

Women Only:

Question		
Are you pregnant or think you may be	YES	NO
Are you nursing	YES	NO
Are you taking birth control pills	YES	NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

*Signature of Patient, Parent, or Guardian*____________________________

For Completion By Dr. Barge

Summary of Dental History: ____________________________

Summary of Medical History: ____________________________

Medical History Update: Initials:

Date	Comments	Patient	Dentist	Hygienist