Claremont Family Dentistry
Dr. Michael J. Gordon DDS, PA
2953 N. Oxford St
Claremont, NC 28610

Date_____ Home Phone_____ Cell Phone _____

Name_____ Sex ____M____F Age_____ Date Of Birth_____
Last First MI

Address_____ City_____ State_____ Zip_____

Marital Status: Married_____ Widowed_____ Single____ Minor____ Separated____ Divorced____ Partnered____

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Work Phone_____

Primary Insurance

Who is responsible for this account?_____ Relationship to Patient?_____

Insurance Co. _____ Group#_____

Subscriber's Name: _____ Birthdate: _____

SSN: _____ Employer: _____

If the patient has additional insurance please notify someone at the front desk
WHEN FILING INSURANCE THE SOCIAL SECURITY NUMBER & DATE OF BIRTH OF THE POLICY HOLDER ARE REQUIRED

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly

To Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature/Relationship:_____ Date:_____

Dental History

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental x-rays _____

Please mark (X) to indicate if you have had any of the following

Bad Breath _____
Bleeding Gums____
Blisters on lips or mouth____
Burning sensation on tongue____
Cigarette, pipe, or cigar smoking____
Dry mouth____
Fingernail biting____
Food collection between teeth____
Grinding teeth_____
Gums swollen or tender____
Jaw pain or tenderness____
Lip or cheek_____
Loose teeth or broken filling____
Mouth breathing____
Mouth pain, brushing____
Orthodontic treatment____
Pain around ear_____
Periodontal treatment_____
Sensitivity to cold____
Sensitivity to sweets____
Sensitivity to heat____
Sensitivity when biting____
Sores or growths in mouth___

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

Health History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These Include Combinations of Ionimin, Adipex, Fastin (brand names of phentermine, Pondimin (fenfluramine) and Redux (dexfenfluramme) ____Yes ____No

Have you ever taken any of the group of drugs collectively referred to as "bisphosphanatas"? These include Fosamax, Zometa, Aredia, Actonel, and Skelid. ____Yes ____No

Do you have a history of bacterial endocarditis? ____Yes _____No *If yes when were you diagnosed? _____

Place a mark on "Yes" or "No" to indicate if you have or have any of the following:

AIDS/HIV	___Yes ___No	Epilepsy	___Yes ___No	Rheumatic Fever	___Yes ___No
Anemia	___Yes ___No	Fainting/Dizziness	___Yes ___No	Scarlet Fever	___Yes ___No
Arthritis, Rheumatism	___Yes ___No	Glaucoma	___Yes ___No	Shortness or breath	___Yes ___No
Artificial Heart Valves	___Yes ___No	Headaches	___Yes ___No	Sinus trouble	___Yes ___No
Artificial Joints	___Yes ___No	Heart Murmur	___Yes ___No	Skin Rash	___Yes ___No
Asthma	___Yes ___No	Heart Problems	___Yes ___No	Special Diet	___Yes ___No
Bleeding abnormally, with		Hepatitis Type____	___Yes ___No	Stoke	___Yes ___No
Extractions or surgery	___Yes ___No	Herpes	___Yes ___No	Swollen Feet/Ankles	___Yes ___No
Blood Disease	___Yes ___No	High blood pressure	___Yes ___No	Swollen Neck Glands	___Yes ___No
Cancer	___Yes ___No	Jaundice	___Yes ___No	Thyroid Problems	___Yes ___No
Chemical dependency	___Yes ___No	Kidney Disease	___Yes ___No	Tuberculosis	___Yes ___No
Chemotherapy	___Yes ___No	Liver Disease	___Yes ___No	Tumor or growth on head	
Circulatory Problems	___Yes ___No	Low Blood Pressure	___Yes ___No	or Neck	___Yes ___No
Congenital Heath Lesions	___Yes ___No	Mitral Valve Prolapse	___Yes ___No	Ulcer	___Yes ___No
Cortisone Treatments	___Yes ___No	Nervous Problems	___Yes ___No	Weightloss, unexplained	___Yes ___No
Cough, persistent/bloody	___Yes ___No	Pacemaker	___Yes ___No		
Diabetes	___Yes ___No	Psychiatric Care	___Yes ___No		
Emphysema	___Yes ___No	Radiation Treatment	___Yes ___No		

Do you wear contact lenses? ___Yes ___No

Women Only:
Are you pregnant? ___Yes ___No Due Date _____ Are you nursing? ___Yes ___No Taking birth control? ___Yes ___No

Medications

Please list any medications you are currently taking:

_____

_____

_____

_____

Allergies

Please mark (X) any of the following to which Are allergic:

Aspirin	____	Local Anesthetic	____
Barbiturates	____	Penicillin	____
Codeine	____	Sulfa	____
Latex	____		

Other (Please Specify): _____

Pharmacy Name _____ Phone: _____

Emergency Contact

Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone_____