108 N. Jefferson Street
Pandora, Ohio 45877
419-384-3278

Putnam Family DENTAL

DR. C. BRAD POHL

15 E. Main Street
Leipsic, Ohio 45856
419-943-2278

PATIENT INFORMATION

Name: _____
Last First MI

I preferred to be called: _____ ☐ Male ☐ Female

Birth date: _____/_____/_____ **SS#** _____-_____-_____

Address: _____

_____ **Mobile**:(____) ____-_____
City State Zip

Home:(_____) _____-_____ **Work**:(_____) ____-_____

Email:_____
interested in text or email reminders? Ask the business office

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Referred by: _____

INSURANCE SUBSCRIBER OR RESPONSIBLE PARTY

Name: _____
Last First MI

Birth date: _____/_____/_____ SS# _____-_____-_____

Address: _____
Street City State Zip

Home:(_____) ____-_____ Mobile:(_____) ____-_____

Work:(_____) ____-_____ Email:_____

I authorize Putnam Family Dental to bill my dental insurance assign all benefits otherwise payable to me and understand any remaining balance is my responsibility.

Signature: _____

If the patient is a ***minor***, please list responsible parents/guardians

Name: _____

Relation: _____ Is a patient? ☐Yes ☐No ☐Unsure

Name: _____

Relation: _____ Is a patient? ☐Yes ☐No ☐Unsure

EMERGENCY Contact Name:

_____

Relation: _____

Phone: (_____) _____-_____

PRIMARY INSURANCE

Ins. Company: _____

Group # _____

Name of Insured: _____

SECONDARY INSURANCE

Ins. Company: _____

Group # _____

Name of Insured: _____

EMPLOYMENT INFORMATION

Employer: _____

Address:

_____

_____

Phone:(_____) _____-_____

Other Family Members

Please list all immediate family members who are current patients:

1) _____

2) _____

3) _____

4) _____

MEDICAL HISTORY

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Primary Care Physician: _____

Are you taking prescription or over/counter drugs? ☐No ☐Yes

Please list: _____

_____

Medical & Dental Allergies: ☐No ☐Yes

_____

Recent Surgical History: ☐No ☐Yes

_____

Do you Smoke: ☐ No ☐ Yes Do you use Tobacco? ☐ No ☐ Yes

Women:
Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week# _____

Are you nursing? ☐ No ☐ Yes

DENTAL HISTORY

Date of last dental visit: _____

Rate your smile:
1 2 3 4 5 6 7 8 9 10

Your current dental health is:
☐ Good ☐ Fair ☐ Poor

Do you brush daily? ☐ No ☐ Yes

Type of bristles? ☐ Hard ☐ Med ☐ Soft

Do you floss daily? ☐ No ☐ Yes

Do you gums bleed? ☐ No ☐ Yes

Mobility in Teeth? ☐ No ☐ Yes

Sensitive to Hot/Cold? ☐ No ☐ Yes

Does your physician require a pre-medication for dental appts?
☐ No ☐ Yes

Please circle any medical condition / disease applicable:

Abnormal Bleeding
AIDS / HIV
Alcohol / Drug Abuse
Alzheimer's / Dementia
Artificial Bones / Joints
Arthritis
Asthma / Difficulty Breathing
Blood Transfusion
Cancer / Radiation
Congenital Heart Defect
Diabetes
Epilepsy / Seizures
Fever Blisters / Herpes
Frequent Headaches
Glaucoma
Hay Fever / Sinus Problems
Heart Attack / Stroke
Heart Murmur
Heart Surgery / Pacemaker
Hemophilia / Abnormal Bleeding
Hepatitis
High/Low Blood Pressure
Kidney Problems / Disease
Liver Disease
Lupus / Anemia
Osteoporosis
Psychiatric Problems
Rheumatic / Scarlet Fever
Shingles
Sickle Cell Disease / Traits
Thyroid Problems
Tuberculosis (TB)
Ulcers / Colitis
Other: _____
_____
_____

I understand that information I have written is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services with my informed consent.

Signature _____ Date ____/____/____