J. Alex Rang DDS, PC.

6700 Darmstadt Rd.
Evansville, IN 47710
(812) 867-2414
alexrangdds.com

Name: _____
Last First MI Title

Preferred Name: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: ____ Zip: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner

How did you hear about our office? _____

Do you prefer to be contacted for appointment confirmation via email or phone? *(circle preference)*

● Insurance - Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

● Insurance - Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

● Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to J. Alex Rang, DDS PC. 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures & treatment by the dentist necessary for proper dental care.

Parent/Guardian Signature: _____

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Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____ Phone: _____

Date of last visit: _____

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

Are you currently under the care of a physician? ☐ Yes ☐ No

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins, implants, joint or valve replacements placed? ☐ Yes ☐ No

Have you had any surgical procedures? ☐ Yes ☐ No

Please list each one: _____

Please list all medications, vitamins, herbals you are currently taking:

_____

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Trasfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Yes	No	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles

Yes	No	Conditions
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Yes	No	If Female, Please Answer
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If so, # of weeks ___
☐	☐	Are you nursing?

Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictist confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

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How may we help you today? _____

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

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now, or have you had any pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Are you under stress? (new job, moving, relationships) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you'd like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you: floss/week _____ brush/day_____

Are your teeth sensitive to heat, cold, anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental visit? _____

When was your last dental cleaning? _____

Why did you leave your previous dentist? _____

How can we accomodate you better during your dental visit? _____

Here at J. Alex Rang DDS, we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like to discuss during your visit:

Orthodontics	Smile Makeover	Cosmetics/Whitening
Dentures/Denture Stabilization	Crown and Bridge	Bonding
Implants	Night/Sport Guards	Veneers