

**GARY W. MOSS, D.D.S.**

Name: \_\_\_\_\_  
Last ( Mr Mrs Miss Ms) \_\_\_\_\_ First \_\_\_\_\_ Middle Int. \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_

Home Address \_\_\_\_\_ Hm. Phone \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip) Work Phone \_\_\_\_\_

Referring Dentist \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

**MEDICAL HISTORY**

Please answer the following and if yes, indicate with a check mark . Please explain.

- \_\_\_\_\_ How would you rate your current health? Good, Fair, Poor.
- \_\_\_\_\_ Have you been hospitalized or had any recent prolonged illness or disease? \_\_\_\_\_
- \_\_\_\_\_ Are you presently under the care of a physician? \_\_\_\_\_
- \_\_\_\_\_ Are you now using any medications? \_\_\_\_\_
- \_\_\_\_\_ Are you sensitive or allergic to any Dental anesthetic? \_\_\_\_\_
- \_\_\_\_\_ Are you sensitive or allergic to any medications or drugs? \_\_\_\_\_
- \_\_\_\_\_ Have you ever had any problems with dental treatment? \_\_\_\_\_
- \_\_\_\_\_ (Women) Are you pregnant or nursing? \_\_\_\_\_
- \_\_\_\_\_ Have you taken Fasomax in the past? \_\_\_\_\_

Do you have or have you had any of the following: If yes indicate with check mark.

- |   |                             |   |
|---|-----------------------------|---|
| _____ Heart disease                         | _____ Glaucoma              | _____ Venereal disease                        |
| _____ Heart attack                          | _____ Diabetes              | _____ Ulcers                                  |
| _____ Heart murmur                          | _____ Epilepsy              | _____ Bleeding problems                       |
| _____ Heart valve replacement               | _____ Convulsions           | _____ Problems healing                        |
| _____ Prosthetic appliance (hip, knee, Etc) | _____ Dizziness or fainting | _____ Liver disease                           |
| _____ Angina pectoralis                     | _____ Asthma                | _____ Alcoholism                              |
| _____ High blood pressure                   | _____ Sinus trouble         | _____ Hepatitis                               |
| _____ Kidney disease                        | _____ A.I.D.S.              | _____ Psychiatric care                        |
| _____ Stroke                                | _____ H.I.V.                | _____ Allergies to Latex,<br>metal, chemicals |
|   |                             | _____ Recreational Drugs                      |

Other **health condition (s)**  
Which we should be aware of: \_\_\_\_\_

Medical Updates, Dr. use only: Date/Init _____ Date/Init _____ Date/Init _____
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**I confirm as true the above medical history information and give consent to agreed upon dental services and use of appropriate methods thereto in my behalf.**

Signed \_\_\_\_\_ Today's Date \_\_\_\_\_  
(Patient, Parent, or Guardian)

IF YOU DO NOT INTEND TO PAY CASH IN FULL TODAY, PLEASE CONTINUE ON REVERSE SIDE.

**PLEASE PROVIDE US WITH THE FOLLOWING DENTAL INSURANCE INFORMATION**

**PRIMARY INSURANCE**

Employee Name \_\_\_\_\_  
Birth Date: \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_  
Wk. Phone \_\_\_\_\_ Ext, \_\_\_\_\_  
Driver License # \_\_\_\_\_  
Dental Ins. Co. \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone (    ) \_\_\_\_\_  
Group # \_\_\_\_\_ Policy # \_\_\_\_\_

**SECONDARY INSURANCE**

Employee Name \_\_\_\_\_  
Birth Date: \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_  
Wk phone \_\_\_\_\_ Ext, \_\_\_\_\_  
Drivers License # \_\_\_\_\_  
Dental Ins. Co. \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone (    ) \_\_\_\_\_  
Group # \_\_\_\_\_ Policy # \_\_\_\_\_

**I hereby authorize my insurance benefits to be paid directly to the office of Dr. Gary Moss. I am financially responsible for services not covered or paid for by my insurance company for any reason. I also authorize this office to release any information required about my dental condition / treatment needed to determine benefits for as long as it takes to have the claim settled.**

( Signed ) \_\_\_\_\_ Date \_\_\_\_\_  
( Patient, Parent or Guardian )

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**FOR OFFICE USE ONLY**

Date \_\_\_\_\_  
Max \_\_\_\_\_  
Ded \_\_\_\_\_  
Endo \_\_\_\_\_  
Major \_\_\_\_\_  
UCR/Fee Sch \_\_\_\_\_  
Amt. Used \_\_\_\_\_  
Name \_\_\_\_\_  
Special Notes : \_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_  
Max \_\_\_\_\_  
Ded \_\_\_\_\_  
Endo \_\_\_\_\_  
Major \_\_\_\_\_  
UCR/Fee Sch \_\_\_\_\_  
Amt. Used \_\_\_\_\_  
Name \_\_\_\_\_