145 Nutt Road
Phoenixville, PA 19460

LOESBERG
DENTAL & ASSOCIATES

Jalol Nur, DMD
610-933-3881

Today's Date: _____ Referred by: _____ Email Address: _____

PATIENT INFORMATON

Last Name: _____ First Name: _____ Preferred Name: _____

Birthdate: _____ Age: _____ Sex: o M oF Social Security #: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship of Emergency Contact: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Subscriber: _____ Is subscriber a patient? oYes oNo

Subscriber's Date of Birth: _____ Social Security #: _____

Subscriber's Address: _____

Subscriber's Employer: _____

Patient's relationship to Subscriber: o Self o Spouse o Child o Other _____

Insurance Plan Name: _____

Member ID#: _____ Group #: _____

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

o AIDS/HIV	o Epilepsy	o Irregular Heartbeat	o Pregnancy
o Anemia	o Excessive Bleeding	o Kidney Disease	o Radiation Treatment
o Arthritis	o Fainting	o Liver Disease	o Rheumatic Fever
o Artificial Joints/valve	o Glaucoma	o Lung Disease	o Sinus Problems
o Asthma	o Head Injury	o Low Blood Pressure	o Steroid Therapy
o Blood Disease	o Heart Attack/Disease	o Mitral Valve Prolapse	o Stomach Problem
o Cancer	o Heart Murmur	o Osteoporosis	o Stroke
o Diabetes	o Hepatitis A/B/C	o Pain In Jaw	o Thyroid Disease
o Epilepsy	o High Blood Pressure	o Pacemaker	o Tuberculosis

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?:

oAspirin oPenicillin oCodeine oLocal Anesthetics oAcrylic oMetal

oLatex oSulfa Drugs oOther, please explain: _____

_____

Are you under the care of a physican? oYes oNo If yes, please explain: _____

_____

Have you had any complications following dental treatment? oYES oNo If yes, please explain: _____

_____

Are you taking any medications? oYes oNo If yes, please list: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and accurate. If I have any change in my health, I will inform the doctors at the time of my next appointment without fail

- **Consent for Services**: I authorize my insurance benefits to be paid directly to the dentist. I understand any costs given are estimates and insurance has final determination.
- I understand it is my responsibility to know my insurance benefits and that I am financially responsible for any unpaid balance.
- SIGNATURE OF PATIENT: _____ DATE: _____