

Dr. Jodie Luther, D.M.D.  
213 East Main Street  
Evans City, PA 16033  
724-538-8480

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Number: \_\_\_\_\_ Allow texting: YES or NO Home Number: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Social Security # \_\_\_\_\_

Present Medication (use back if necessary): \_\_\_\_\_

Allergies: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Are you aware of any major health problems? \_\_\_\_\_

Have you had any serious illness, operations or have been hospitalized in the past 5 years? Yes or No  
If yes, what was the illness or problem \_\_\_\_\_

Are you sensitive to Metals or Latex?	Y or N	Are you diabetic?	Y or N
Do you have high or low blood pressure?	Y or N	Could you be pregnant?	Y or N
Do you have epilepsy or seizure disorders?	Y or N	Do you have HIV or Aids?	Y or N
Do have inflammatory or auto immune disease?	Y or N	Do you bleed excessively?	Y or N
Do you have artificial joints, prosthesis or heart valves?	Y or N	Do you consume alcohol?	Y or N
Have you been treated with chemotherapy or radiation?	Y or N	Do you have heart disease?	Y or N
Are your teeth sensitive to cold, hot, sweet or pressure?	Y or N	Do you have/had TB or hepatitis?	Y or N
Are you currently experiencing dental discomfort or pain?	Y or N	Do you smoke, vape, chew, or use snuff?	Y or N
Have you ever had a serious injury to your head or mouth?	Y or N	Have you had any periodontal treatments?	Y or N
Do you have respiratory problems, bronchitis, emphysema or COPD?	Y or N		

Date of last dental exam: \_\_\_\_\_ Date of last x-ray: \_\_\_\_\_  
Dental Insurance Co.: \_\_\_\_\_ ID# \_\_\_\_\_ Are you the subscriber? Y or N  
If NO, subscribers name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

**I Release:**

I authorize the dentist to perform diagnostic and treatment as may be necessary for proper dental care.  
I authorize the release of any information concerning my health care, advice and treatment to another dentist.  
I authorize the release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.  
I understand that my dental care insurance may pay less than the actual bill for service. I understand I am financially responsible for payment in full of all services not paid in full or in part by my dental insurance carrier.  
I attest to the accuracy of the information on this page.

**I have reviewed the posted copy of the Notice of Privacy Practices & Written Financial Policy**

**\$45 cancellation fee-** if appointment is not canceled/rescheduled 24 hours in advance of scheduled time. (Initial) \_\_\_\_\_

**Bank/Credit card fee-** we will be charging a convenience fee of 3%. No charge on Health savings cards. (Initial) \_\_\_\_\_

Patient's/Guardian's  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_