PATIENT INFORMATION

Date_____

☐Mr ☐Mrs ☐Ms ☐Dr

Patient_____
First Middle initial Last

Address_____
Street

_____
City State Zip

Patient's Phone_____
Home Work

_____
Cell phone E-mail

Sex ☐ **M** ☐ **F** **Age**_____ **Birthdate**_____

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Soc. Sec. No._____

Occupation_____

Employer_____

Employer's Address_____

Employer Phone(____)_____

Patient's Dental Insurance Carrier_____

Group #_____ **Union Local #**_____

Spouse's Name_____
(Parent) First Middle initial Last

Spouse's Address (if different)_____
Street

_____
City State Zip

Spouse's Phone_____
Home Work

Spouse's Date of Birth_____

Spouse's Employer_____
Name (business name if self-employed)

_____
Street City State Zip

Spouse's Occupation_____

Spouse's Soc. Sec. No._____

Spouse's Dental Insurance Carrier_____

Group#_____ **Union Local #**_____

Whom may we thank for referring you?

_____
Name Address

Party responsible for this account_____

Billing Address (if different from above)_____

Patients are always responsible for payment of their bill EVEN if they have dental insurance. It is not always possible to predict which services are covered by the carrier or how much they will pay for a particular service. We will assist you in every way possible with your insurance carrier. I understand that a 1.5% finance charge (18% annually) will be added to all balances over 90 days.

RELEASE AND ASSIGNMENT

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled.

Signed_____ **Date**_____

CONSENT FOR PROFESSIONAL SERVICES

I hereby authorize E.C.Lobo-Marwah D.D.S, Inc, and/or the dentist in charge of my care and their auxiliaries to administer any treatment, anesthetics, and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my case after discussion of the proposed treatment, alternatives and implications. I understand that results are not guaranteed or warranted and cannot be guaranteed or warranted.

Date_____ **Signed**_____

DENTAL HISTORY

Please circle "Y" or "N" to indicate if you have any of the following

Reason for today's visit_____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental X-rays_____

Bad breath	**Y**	**N**	**Jaw pain or tiredness**	**Y**	**N**
Bleeding gums	**Y**	**N**	**Chew on one side only**	**Y**	**N**
Do you smoke	**Y**	**N**	**Clicking or popping jaw**	**Y**	**N**
Dry Mouth	**Y**	**N**	**Sensitivity to hot, cold or sweets**	**Y**	**N**
Mouth breathing	**Y**	**N**	**Sensitivity to biting**	**Y**	**N**
Pain around ear	**Y**	**N**	**Grinding or clenching of teeth**	**Y**	**N**

HEALTH HISTORY

Your Name _____

Physician's Name _____ Phone # _____ Date of Last Visit _____

Please circle "Y" or "N" to indicate if you have had any of the following:

AIDS/HIV Positive	Y	N	Epilepsy	Y	N	Psychiatric Care	Y	N
Anemia	Y	N	Fainting or dizziness	Y	N	Radiation Treatment	Y	N
Arthritis, Rheumatism	Y	N	Glaucoma	Y	N	Respiratory Disease	Y	N
Artificial Heart valves	Y	N	Headaches	Y	N	Rheumatic Fever	Y	N
Artificial Joints	Y	N	Heart Murmur	Y	N	Scarlet Fever	Y	N
Asthma	Y	N	Hepatitis	Y	N	Shortness of Breath	Y	N
Back Problems	Y	N	Type_____	Y	N	Sinus Trouble	Y	N
Bleeding abnormally, with	Y	N	Herpes	Y	N	Skin Rash	Y	N
Extractions or surgery	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Blood disease	Y	N	Jaundice	Y	N	Swelling of Feet or Ankles	Y	N
Cancer	Y	N	Jaw Pain	Y	N	Thyroid Problems	Y	N
Chemical Dependency	Y	N	Kidney Disease	Y	N	Tonsillitis	Y	N
Chemotherapy	Y	N	Low Blood Pressure	Y	N	Tuberculosis	Y	N
Circulatory Problems	Y	N	MitralValve Prolapse	Y	N	Tumor or growth on head	Y	N
Congenital Heart Lesions	Y	N	Nervous Problems	Y	N	or neck		
Cortisone Treatments	Y	N	Pacemaker	Y	N	Ulcer	Y	N
Cough, persistent or	Y	N	Women:			Venereal Disease	Y	N
bloody			Are you pregnant?	Y	N			
Diabetes	Y	N	Due date_____			Unexplained weight loss	Y	N
Emphysema	Y	N	Are you nursing?	Y	N		Y	N

Do you have any disease, condition or problem not listed above that you think I should know about?_____

_____

MEDICATIONS	ALLERGIES
Please list medications you are currently taking:	Circle if allergic to item
	Aspirin — Local Anesthetic
	Barbiturates — Penicillin
Have you ever taken Fen-Phen? Y N	Codeine — Sulfa
Have you ever taken Redux? Y N	Iodine — Other_____
Have you ever taken Fosamax, Boniva, or Actonel ? Y N	Latex
Have you ever been given Zometa, Aredia or Didronel? Y N	
DATE PATIENT'S/PARENT'S SIGNATURE	DOCTOR'S SIGNATURE

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Y N

For what conditions? _____

Are you taking any new medications? _____ If so what? _____

_____

Patient's signature _____ Date _____

Doctor's signature _____ Date _____