Zsambeky, Chaney & Associates

PATIENT INFORMATION

Patient Name:____ Prefers: ________________ Date: __________
LAST FIRST MI

❍ MALE ❍ FEMALE ❍ Married ❍ Single ❍ Child ❍ Other: __________ Birth Date: ______________________

Social Security #: ___________________ How did you hear about our office?_____________________________

Address:____
STREET APARTMENT # CITY, STATE ZIP CODE

Home Phone:_________________ Cell Phone: ______________ Accept Text Messages? YES NO EMAIL:______________

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name:____ ❍ MALE ❍ FEMALE

Relationship to Patient: ____

Social Security #: ____ Birth Date: _________________________

Home Phone: ____________________________________ Cell Phone:_______________________________________

Address: ____
STREET APARTMENT # CITY, STATE ZIP CODE

EMPLOYMENT INFORMATION

Employer's Name: ____ Occupation: _________________

Address of Employer: ____
STREET CITY, STATE ZIP CODE

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE Name of Policyholder: ____

Is insured a patient? ❍ YES ❍ NO Insured's Birth Date: ______________ID#: ____________ Group #: ________________

Insured's Employer Name and Address: ____

____

Patient's relationship to insured: ❍ Self ❍ Spouse ❍ Child ❍ Other ______________________________________

Insurance Plan Name and Address: ____

____

CONSENT FOR SERVICES AND PRIVACY POLICY

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as deemed appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others who may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

By signing below, I am testifying that the above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for any errors omissions that I may have made in the completion of this form.

DATE: ______________________________________ SIGNATURE: ____

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HAVE READ THE NOTICE OF PRIVACY PRACTICES FOR THE ABOVE NAMED PRACTICE.

DATE: ______________________________________ SIGNATURE: ____

MEDICAL HISTORY INFORMATION

Physician's Name:______________________________________ Phone#:____

*Are you under a doctor's care now? ❍YES ❍NO If yes, please describe: ____

*Any illnesses/operations/hospitalizations in past 2 years? ❍YES ❍NO If yes, please describe: ______________________________

*(Women) Are you pregnant? ❍YES ❍NO Due Date: ________ Nursing? ❍YES ❍NO Taking birth control? ❍YES ❍NO

*Do you take, or have you taken, Phen-Fen or Redux? ❍YES ❍NO ____

*Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonates? ❍ YES ❍ NO________________________________

*List any medications you are currently taking ____

*Please list any allergies to drugs, medications, anesthetics, or latex____

IF YOU HAVE ANY OF THESE MEDICAL CONDITIONS, PLEASE CHECK THE APPROPRIATE BOX. IF MORE THAN ONE IS LISTED, PLEASE CIRCLE THE SELECTION THAT APPLIES TO YOU:

□ Alzheimer's Disease
□ Alcoholism/Drug Addiction
□ Asthma
□ Autism
□ Neurological Problems
□ Epilepsy/Seizures
□ Diabetes
□ Kidney Problems
□ Dialysis
□ Liver Problems
□ Eye Disorder/Glaucoma
□ Arthritis/Rheumatism
□ Sleep Disorders: Snoring/ Sleep Apnea/Insomnia
□ Hives or Skin Condition

□ ADD/ADHD
□ High Blood Pressure
□ Low Blood Pressure
□ High Cholesterol
□ Stroke _____ year
□ Thyroid Problems
□ AIDS/HIV/ARC
□ Tonsilitis
□ Tobacco Use: cigars, cigarettes, smokeless
□ Respiratory Problem
□ Hay Fever
□ Sinus Problems
□ Persistent Cough
□ Tuberculosis

□ Bacterial Endocarditis
□ Blood Disease
□ Sickle Cell
□ Anemia/Blood Problems
□ Hemophilia
□ Hepatitis A / B / C
□ Blood Transfusion ____ year
□ Sexually Transmitted Disease
□ Psychiatric Problems/Care
□ Cancers/Tumors/Leukemia
□ Radiation Treatments
□ Chemotherapy
□ Cataracts
□ Sudden Weight Gain/Loss
□ Yellow Jaundice

□ Heart Murmur/Mitral Valve Prolapse
□ Heart Attack _______ year
□ Angina/Chest Pain
□ Rheumatic Heart Fever/Disease
□ Heart Pacemaker ______ year
□ Heart Surgery _____ year
□ Artificial Heart Valves _____ year
□ Congenital Heart Disorder
□ Congestive Heart Failure
□ GI Disorders: IBD/GERD/Celiac/ Ulcers/Colitis/Reflux/Bypass/Crohn's
□ ANY Artificial: Knee, Hip, Joints, Pins, Plates _______ year
□ Circulatory Problems
□ Frequent Headaches or Migraines

DENTAL HISTORY INFORMATION

Date of Last Dental visit/x-rays:____________ Previous Dental Provider Name & phone number: ______________________________

If you could change one thing about your smile, what would it be? ____

How often do you brush?__________________ floss? ______________Have your wisdom teeth been removed? ❍ YES ❍ NO

PLEASE CHECK IF YOU HAVE, OR EVER HAD ANY OF THE FOLLOWING:

□ Clenching or Grinding Teeth
□ Bleeding Gums
□ Bad Breath/Bad Taste in Mouth
□ Sensitive to Hot

□ Clicking or popping Jaw/TMJ
□ Loose teeth
□ Periodontal Treatment
□ Sensitive to Cold

□ Muscle soreness in face
□ History of dental decay
□ Sores in Mouth
□ Sensitive to Sweet

□ Food collection between teeth
□ Broken fillings and/or chipped teeth
□ Mouth breathe while sleeping
□ Sensitive to Pressure/Biting/Chewing

Have you lost any teeth or have any teeth been removed? ❍ YES ❍ NO If yes, are you interested in dental implants? ❍ YES ❍ NO

Have you ever experienced any head/face injury or trauma? ❍ YES ❍ NO If yes, please describe ____________________________

Have you had any orthodontic work? ❍ YES ❍ NO If yes, please give Orthodontist and year of treatment ___________________

If we find something that needs to be done in your mouth, do you want ❍ Details OR ❍ Big Picture/Overview

Any other questions or concerns not addressed on this form?____

_______________________________________ ____________________________

Patient's (Guardian's) Signature Date