Port Isabel Dental Associates

Patient Information:

Date _____ SS#: _____

Name_____

Mailing Address _____

_____

Physical Address _____

_____

Sex: ___M ___F Age_____ Birthdate_____

__Single __Married __Separated __Widowed __Divorced

Occupation _____

Employer_____

Employer Phone (_____)_____

Spouse's Name _____

Birthdate _____ SS#_____

Spouse's Ph# (_____)_____

Spouse's Employer_____

Has any member of your immediate family ever been a patient of our practice? ___No ___Yes

if "yes" please list
names :_____

Dental Insurance:

Who is responsible for this account?_____

Relationship to patient_____

Insurance Co_____ Ph#_____

Group #_____

Birthdate_____ ID#_____

Social Security # of Insured _____

Is patient covered by additional insurance?__Yes __No

Relationship to patient_____

Insurance Co_____ Ph#_____

Birthdate_____ ID#_____

Social Security # of Insured _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Port Isabel DENTAL ASSOCIATES all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Phone Numbers

Home (_____)_____ **Work** (_____)_____ **Cellular** (_____)_____

Best time to reach you_____ Email Address_____

Would you like for our office to send you courtesy appointment reminders via Email? _____Yes _____No

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name_____ Relationship_____

Home Phone (_____)_____Work (_____)_____Cellular(_____)_____

How Did You Hear About Our Office?

__Internet-Website __Insurance __Local Phone Book (Small Book) __PI Press __Building/Location

__Word of Mouth __ Marketing in Community __Patient or Staff -If so, please give us the name so that we may send thanks: _____ Other: _____

The information I have provided on all pages of my 'New Patient' paperwork is correct to the best of my knowledge.

Patient's **Signature**: _____ Date: _____

If patient is under the age of 18, signature of Parent or Legal Guardian:

Parent or Legal Guardian: _____ Date:_____

Getting to know You…

What is your primary reason for this dental appointment:

___Examination ___Consultation ___Professional Cleaning & Exam ___Cosmetic Procedure ___Implant(s)

___Laser Whitening ___Emergency / Details:_____

Why did you leave your former dentist?

_____

What do you feel is the most important quality that a dentist should have? _____

_____

Are you pleased with your current dental condition? ___Yes ___No If not, then what would you change? _____

_____

Medical History

___Abnormal Bleeding
___AIDS or HIV Positive
___Allergies to Anesthetics
___Allergies to Drugs
___Allergies—Other
___Arthritis
___Artificial Heart Valves
___Asthma or Hay Fever
___Back Problems
___Blood Disease
___Cancer
___Chemical Dependency
___Chest Pain
___Chronic Diarrhea
___Circulatory Problems
___Congenital Heart Disease
___Diabetes
___Epilepsy / Convulsions
___Emphysema
___Fainting Spells
___Glaucoma
___Grinding Teeth
___Heart Murmur
___Heart Problems
___Hepatitis or Jaundice
___Hemophilia
___High Blood Pressure
___Hypoglycemia
___Irregular Heart Beat
___Kidney Trouble
___Liver Disease
___Low Blood Pressure
___Mitral Valve Prolapse
___Nervous Problems
___Pacemaker
___Pain in Jaw / Joints
___Previous Head Injuries
___Psychiatric Care
___Radiation Treatment
___Respiratory Disease
___Seizures
___Sinus Problems
___Special Diet
___Stroke
___Swollen Neck Glands
___Venereal Disease
___Tuberculosis
___Tumor / Growth
___Swollen Ankles
___Recent Weight Loss
___Rheumatic Fever
___Ulcer
___Jaw/Joints Problems
___Clicking/Popping of Jaw
___Frequent Headaches
___Traumatic Head Injury

Allergies to Sulfites: __Yes __No

Allergic to Penicillin, Codeine, Aspirin or Other drugs? ___Yes ___No If "yes," Please list: _____

_____

Allergic to Latex or Acrylic : __Yes __No

Any Food Allergies? ___Yes ___No

Allergies to any Metals/Jewelry: ___Y ___N

Thyroid Problems? ___Yes ___No

Women: Are you pregnant ? __Yes __No

Have you ever had a bad reaction to any Anesthetic in a Dental Office? ___Yes ___No If "yes," how long ago? _____

Do you have osteoporosis? ___Yes ___No If "yes," are you taking Fosamax or any other Medication for osteoporosis? ___Y ___N

List medications: _____

Do you take Aspirin on a daily or regular basis? ___Yes ___No

Do you take any form of Anti-Depressant Medication? ___Yes ___No

Do you have a history of jaw/joint problems or TMD Syndrome? ___Y ___N

Do you have any health problems/issues not mentioned above? ___Yes ___No If "yes," please describe: _____

_____

Medical Physician's Name: _____City/State:_____

Are you currently under the care of a Physician? ___Yes ___No If "yes," explain: _____

_____

_____

Have you ever been hospitalized? ___Yes ___No If "yes," please give more detail: _____

_____

_____

_____

_____

Please list all the **Medications** and/or **Herbal Supplements** you are currently taking:_____

_____

_____

_____

Do you require any medications PRIOR to ANY DENTAL treatment? ____ Yes ____No If "yes," please list Medication(s):

_____