POMERADO COSMETIC DENTISTRY

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PATIENT INFORMATION

◉ Mr. ○ Mrs. ○ Ms. ○ Dr. First Name _____ M.I. ____ Last Name _____ Preferred Name _____

Sex: ☐ Male ☐ Female Birth Date _____ Age ____ Soc. Sec. # _____ E-mail _____

Address _____ City _____ State ____ Zip _____

Home Tel (____) _____ Cell(____) _____ Referred By _____

Prev. Dentist _____ Tel (____) _____ Medical Doctor _____ Tel (____) _____

Nearest relative not living with you _____ Tel (____) _____

Employer _____ Tel (____) _____

In case of emergency, please contact _____ Tel (____) _____ Relation _____

Spouse or other guarantor information (if different from above)

Name _____ Relation _____ S.S.# _____ Birth Date _____

Address _____ City _____ State ____ Zip _____

Tel. (____) _____ Employer _____ Bus. Tel. (____) _____

INSURANCE INFORMATION

Flex Spending Account or Heath Savings Account: yes ☐ no ☐

Student: ◉ Full Time ○ Part Time ○ N/A School Name: _____

Status: ◉ Married ○ Divorced ○ Widow ○ Legally Separated ○ Single ○ Partner

Employed: ◉ Full Time ○ Part Time ○ Retired ○ Self -Employed ○ N/A

PRIMARY INSURANCE COMPANY

Insurance Type: ☐ Dental **Plan Name:** _____

Employer _____

Address _____

Tel (___) _____

Insurance Company _____

Address _____

Tel (____) _____

Group # _____

Insured Party _____ Relation _____

Sex: ☐ M ☐ F Birth Date _____

Address (of insured party) _____

City, State, Zip _____

Tel (____) _____ S.S.# _____

Dental I.D.# _____

SECONDARY INSURANCE COMPANY

Insurance Type: ☐ Dental **Plan Name:** _____

Employer _____

Address _____

Tel (___) _____

Insurance Company _____

Address _____

Tel (____) _____

Group # _____

Insured Party _____ Relation _____

Sex: ☐ M ☐ F Birth Date _____

Address (of insured party) _____

City, State, Zip _____

Tel (____) _____ S.S.# _____

Dental I.D.# _____

DENTAL INFORMATION

Reason for today's visit: _____ Are you in pain? ☐ No ☐ Yes, for how long? _____

Please indicate any of the following problems by checking off the corresponding box:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Discomfort, clicking, or popping in jaw	☐	☐	Lost / broken filling(s)	☐	☐	Stained teeth	☐	☐	Difficulty closing jaw
☐	☐	Red, swollen, or bleeding gums	☐	☐	Teeth grinding / clenching	☐	☐	Locking jaw	☐	☐	Difficulty opening jaw
☐	☐	A removable dental appliance	☐	☐	Ringing in ears	☐	☐	Bad breath	☐	☐	Loose / shifting teeth
☐	☐	Blisters / sores in or around the mouth	☐	☐	Broken / chipped tooth	☐	☐	Burning tongue / lips	☐	☐	Food caught between teeth
☐	☐	Prolonged bleeding from an injury / extraction	☐	☐	Gum disease	☐	☐	Toothache	☐	☐	Swelling / lumps in mouth
☐	☐	Recent infections or sore throat	☐		Other:						
☐	☐	My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting									

Last dental exam _____ Last dental x-rays _____ How many times a day do you brush? _____ Floss? _____

How would you rate your smile? (worst) ○○○○○○○○○○ (best) Would you like whiter teeth? ☐ Yes ☐ No

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

MEDICAL HISTORY

Are you in good health? ☐ Yes ☐ No Are you under the care of a physician? ☐ Yes ☐ No Physician's Name: _____

Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No Please list: _____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Mitral valve prolapse	☐	☐	Blood disorder	☐	☐	Kidney trouble	☐	☐	Alzheimer's
☐	☐	Heart murmur	☐	☐	Abnormal bleeding	☐	☐	Are you on dialysis	☐	☐	Mental health problems
☐	☐	High blood pressure	☐	☐	Anemia	☐	☐	Delay in healing	☐	☐	Thyroid trouble hypo or hyper
☐	☐	Low blood pressure	☐	☐	Hemophilia	☐	☐	Diabetes Type I or II	☐	☐	Arthritis/Joint disease
☐	☐	Chest pain/Angina	☐	☐	Bronchitis/Chronic cough	☐	☐	Cortisone treatments	☐	☐	Osteoporosis/Osteopenia
☐	☐	Heart attack(s) Date:_____	☐	☐	Asthma	☐	☐	Are you immuno-suppressed	☐	☐	Osteonecrosis
☐	☐	Irregular heart beat	☐	☐	Snoring/Sleep apnea	☐	☐	Jaundice/Liver disease	☐	☐	Artifical joints
☐	☐	Cardiac pacemaker (shielded)	☐	☐	Respiratory problems	☐	☐	Hepatitis A / B / C (circle one)	☐	☐	HIV or AIDS
☐	☐	Heart surgery Type:_____	☐	☐	Tuberculosis	☐	☐	Stomach ulcers	☐	☐	Contagious diseases
☐	☐	Chronic fatigue/Night sweat	☐	☐	Emphysema	☐	☐	Eye disease/Glaucoma	☐	☐	Shingles
☐	☐	Difficultly climbing 1–2 flights of stairs	☐	☐	Do you smoke	☐	☐	Hearing problems	☐	☐	Sexually transmitted diseases
			☐	☐	Do you use chewing tobacco	☐	☐	Parkinson's	☐	☐	A history of substance abuse
☐	☐	Previous case of endocarditis	☐	☐	Cancer type:_____	☐	☐	Dimentia	☐	☐	A history of drug use
☐	☐	Stroke/TIA	☐	☐	Tumor or growth	☐	☐	Fainting spells			
☐	☐	Swollen ankles, Edema	☐	☐	Radiation/Chemotherapy	☐	☐	Convulsions/Epilepsy			
☐	☐	Artifical heart valves	☐	☐	Low blood sugar	☐	☐	Headaches			

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

Y	N		Y	N		Y	N	
☐	☐	Anxiety medication	☐	☐	Pain killers (incuding aspirin)	☐	☐	Muscle relaxers
☐	☐	Blood thinners (Coumadin, Aspirin)	☐	☐	Tranquilizers	☐	☐	Insulin
☐	☐	Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)						

Y	N		Y	N	
☐	☐	Stimulants	☐	☐	Anti-depressants

Please list any medication(s) you are taking (including natural, herbal, or homeopathic products):

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N	
☐	☐	Penicillin /Antibiotics	☐	☐	Local anesthetic (numbing med)	☐	☐	Anti–Anxiety meds
☐	☐	Latex	☐	☐	Codeine or other narcotics			
☐	☐	Sulfa drugs/sulfites	☐	☐	Iodine			

Please list any medication(s) or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(women note:antibiotics (such as penicillin) may alter the effectiveness of birth control pills consult your physician / gynecologist for assistance regarding additional methods of birth control)*

1) Is there a possibility of pregnancy? ☐ Yes ☐ No 2) Expected delivery date: _____

3) Are you nursing? ☐ Yes ☐ No 4) Are you taking birth control pills? ☐ Yes ☐ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X