welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date___________ Soc. Sec. #__________________________ Birthdate_____________

Name____
Last name First name Initial

Address____ Home Phone___________

City______________________________________ State___________ Zip___________

Sex __M__F ____Minor____Single____Married____Long term partner___Divorced____Widowed___Seperated

Employer____Business Phone___________

Business Address________________________________Occupation________________

Who should we thank for referring you?_______________________________________

In case of emergency, who should we contact?_________________Phone___________

Primary Insurance

Person responsible for account____
Last name First name Initial

Relationship to patient__________________Birthdate_________Soc. Sec #___________

Address____Home phone____________

City________________________________State_________________Zip____________

Insurance Company & Address____

Subscriber I.D.#___________________________________Group #_________________

Dental History

Former dentist_______________________________ Date of last visit______________

How often do you floss?__________________How often do you brush?______________

Please check all that apply:

Bad breath ___ Loose teeth or broken fillings ____ Sensitivity to sweets ___

Bleeding gums ___ Orthodontic treatment ____ Sensitivity when biting ____

Blisters on lips/mouth ___ Pain around ear ___ Frequent headaches ___

Finger nail biting ___ Periodontal treatment ____ Jaw, Head or Neck injuries ___

Grinding teeth ___ Sensitivity to cold ___ Jaw difficulty: Clicking and/or pain ____

Lip or cheek biting ___ Sensitivity to heat ____ Tooth pain ____

Medical History

Physician's Name_____________________________________Date of last visit_______

1.Are you currently under medical treatment? Yes___No___

2.Have you ever had any serious illness or operations? Yes___No___

3.Are you currently taking any medications? Yes___No___

Please describe:_________________________________

____

4. Do you smoke? Yes___No___
5. Do you use alcohol, cocaine, or other drugs? Yes___No____
6. Do you wear contact lenses? Yes___No____
7. **Have you had any allergic reactions to the following:**

Local anesthetics (eg. Novocaine) Yes___No___ Penicillin or other antibiotics Yes___No___

Sulfa drugs Yes___No___ Barbiturates (sleeping pills) Yes___No___ Sedatives Yes___No___

Iodine Yes___No___ Aspirin Yes___No___ Other Yes___No___

8.(Women only) Are you:

Pregnant? Yes___No___ Nursing? Yes___No___ Taking birth control pills? Yes___No___

Please check all that apply:

Aids ____
Anemia ____
Arthritis, Rheumatism ___
Artificial Heart Valves ___
Artificial joints ___
Asthma ___
Back problems ___
Bleeding w/extractions
Or surgery ___
Blood disease ___
Cancer ___
Chemical dependency ___
Mitral valve prolapse ___
Psychiatric care ___
Rheumatic fever ___
Sinus trouble ___
Swelling of feet/ankles ___
Tonsillitis ___
Ulcer ___

Chemotherapy ___
Chronic fatigue syndrome ___
Circulatory problems ___
Congenital heart lesions ___
Cortisone treatments ___
Cough- persistent or bloody ___
Diabetes ___
Emphysema ___
Epilepsy ___
Fainting ___
Glaucoma ___
Headaches ___
Nervous problems ___
Radiation treatment ___
Scarlet fever ___
Skin rash ___
Swollen neck glands ___
Tuberculosis ___
Venereal disease ___

Heart murmur ___
Heart problems ___
Hepatitis-Type ___
Herpes ___
High blood pressure ___
HIV positive ___
Jaundice ___
Jaw pain ___
Kidney disease ___
Latex sensitivity ___
Liver disease ___
Low blood pressure ___
Pacemaker ___
Respiratory disease ___
Shortness of breath ___
Stroke ___
Thyroid problems ___
Tumor/growth on head or neck ___

Assignment and Release

I hearby authorize payment directly to ___________________________ for all insurance benefits Otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible party _______________________________________date __________

Notice of Privacy Practice

(To be filled out at the arrival of the office)

I,____ have received a copy of
(Name of Patient)

________Lefter J. Baklas D.M.D__________________Notice of Privacy Practices
(Name of Practice)

____
(Signature of Patient)

Staff will fill out this section if patient's signature not obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

______Patient refused to sign.
______Emergency situation kept us from obtaining the patient's signature.
______Language barriers kept us from obtaining the patient's signature.
______Other_____________________________