Shelly's Smile Neighborhood Dental

Patient Information and History

Patient Information

Date: ________________

Patient Name: ______________________________________
Last First MI

Please circle the appropriate answer

Male Female Single Married Child Other: __________

Age: ___ Date of Birth: _________ SS#: ______________

Address: ______________________________________

____
City State Zip

Email Address: ______________________________________

May we contact you to confirm appointments at the above email address? Yes No

Occupation: ______________________________________

Employer: ______________________________________

Employer Address: ______________________________________

____
City State Zip

Employer Phone: ______________________________________

Spouses Name: ______________________________________

Date of Birth: __________ SS#: ______________________

Occupation: ______________________________________

Spouse's Employer: ______________________________________

Whom may we thank for referring you? ______________

____

Dental Insurance

Name of Insured: ______________________________________
Last First MI

Is insured a patient? Yes No Insured's Date of Birth: ______

ID #: ______________ Group #: ________________

Insured's Address: ______________________________________

____
City State Zip

Insured's Employer Name: ______________________________________

Employer's Address: ______________________________________

____
City State Zip

Patient's relationship to insured: Self Spouse Child

Other: ______________________________________

Insurance Plan Name and Address: ______________________

____

____

ASSIGNMENT AND RELEASE: I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance company and assign directly to Dr. Sigal Zohar, DDS, PA 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.

____
Insured's Signature

____
Relationship to Patient Date

Phone Numbers

Home: ______________ Work: ________________ Cell: ______________ Spouse's Work: ____________

Best time and place to reach you: ______________________________________

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

Name: ______________________ Relationship: ______________ Home Phone: ________________

Work Phone: ______________ Cell Phone: ______________ Best Phone to contact: Home Work Cell

Medications and Allergies

List any medications you are currently taking: ______________________________________

____

Please check any allergies you have:

_______Aspirin _______Barbiturates (Sleeping Pills) _______Codeine _______Iodine

_______Latex _______Local Anesthetic _______Penicillin _______Sulfa

Other: ______________________________________

Health History

Physician's Name: ______________________ Date of Last Visit: ______________

Please circle "Yes" or "No" to indicate if you have had any of the following:

AIDS	Yes	No	Epilepsy	Yes	No	Psychiatric Care	Yes	No
Anemia	Yes	No	Fainting or Dizziness	Yes	No	Radiation Treatment	Yes	No
Arthritis, Rheumatism	Yes	No	Glaucoma	Yes	No	Date: ________		
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Respiratory Disease	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Rheumatic Fever	Yes	No
Date: __________			Heart Problems	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No	Shortness of Breath	Yes	No
Back Problems	Yes	No	Type: ________			Sinus Trouble	Yes	No
Bleeding Abnormally with			Herpes	Yes	No	Skin Rash	Yes	No
Extractions or Surgery	Yes	No	High Blood Pressure	Yes	No	Special Diet	Yes	No
Blood Disease	Yes	No	HIV Positive	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Jaundice	Yes	No	Swelling of Feet		
Type: __________			Jaw Pain	Yes	No	or Ankles	Yes	No
Chemical Dependency	Yes	No	Kidney Disease	Yes	No	Swollen Neck Glands	Yes	No
Chemotherapy	Yes	No	Liver Disease	Yes	No	Thyroid Problems	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	Tonsillitis	Yes	No
Congenital Heart Lesions	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Cortisone Treatments	Yes	No	Nervous Problems	Yes	No	Tumor or Growth		
Cough, Persistent or			Pacemaker	Yes	No	on Head or Neck	Yes	No
Bloody	Yes	No	Women:			Type: ________		
Diabetes	Yes	No	Are you nursing?	Yes	No	Date: ________		
Emphysema	Yes	No	Are you pregnant?	Yes	No	Ulcer	Yes	No
Do you wear contacts?	Yes	No	Due Date: __________			Unexplained Weight Loss	Yes	No
						Venereal Disease	Yes	No

Dental History

Reason for today's visit: ______________________________________

Former Dentist: __________ City/State: ____________ Date of Last Visit: _____ Date of Last X-rays: ____

Please circle "Yes" or "No" to indicate if you have had any of the following:

Bad Breath	Yes	No	Fingernail Biting	Yes	No	Mouth Breathing	Yes	No
Bleeding Gums	Yes	No	Food Collection			Mouth Pain, Brushing	Yes	No
Blisters on lips/mouth	Yes	No	Between the Teeth	Yes	No	Orthodontic Treatment	Yes	No
Burning Sensation on Tongue	Yes	No	Foreign Objects	Yes	No	Pain Around Ear	Yes	No
Chew on One Side			Grinding Teeth	Yes	No	Periodontal Treatment	Yes	No
Of Mouth	Yes	No	Gums Swollen or Tender	Yes	No	Sensitivity to Cold	Yes	No
Cigarette, Pipe, or			Jaw Pain or Tiredness	Yes	No	Sensitivity to Heat	Yes	No
Cigar Smoking	Yes	No	Lip or Cheek Biting	Yes	No	Sensitivity to Sweets	Yes	No
Clicking or Popping Jaw	Yes	No	Loose Teeth or			Sensitivity when Biting	Yes	No
Dry Mouth	Yes	No	Broken Fillings	Yes	No	Sores/Growths in Mouth	Yes	No

How often do you floss? ____________________ How often do you brush? ____________________

Signatures

Patient's Signature: ______________________________ Date: __________

Doctor's Signature: ______________________________ Date: __________