Patient Information

Name: _____ Birthdate: _____

Phone #: _____ Email: _____

Address: _____ City/State/Zip: _____

Sex Assigned at Birth (Circle One): M F Gender: _____

Employer/School: _____ Spouse/Parent's Name: _____

Whom may we thank for referring you? _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

Responsible Party

Name of Person Responsible for this Account: _____

Relationship to Patient: _____ Address: _____

Phone #: _____ Employer: _____

Birthdate: _____ Currently a patient in our office? (Circle One): Y N

Email: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____

Employer: _____ Employer Address: _____

Insurance Company: _____ Group #: _____Union or Local #: _____

Address: _____City: _____ State: _____ Zip: _____

Deductible: _____ Amount of Deductible Used: _____ Max Annual Benefit: _____

Additional Insurance

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____

Employer: _____ Employer Address: _____

Insurance Company: _____ Group #: _____Union or Local #: _____

Address: _____City: _____ State: _____ Zip: _____

Deductible: _____ Amount of Deductible Used: _____ Max Annual Benefit: _____

Dental History

Reason for Today's Visit: _____ Date of Last Dental Care: _____

Former Dentist: _____ Date of Last Dental X-Rays: _____

Place a check (✓) in the box next to any problems you currently have or have experienced in the past:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collection Between Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Sores/Growths in Your Mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Primary Care Doctor's Name: _____ Date of Last Visit: _____

Do you see any other physicians? If so, please list their names and the reason: _____

_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations: ☐ Yes ☐ No

If yes, please describe: _____

_____

Have you ever had a blood transfusion: ☐ Yes ☐ No | If so, give approximate date(s): _____

Are you pregnant: : ☐ Yes ☐ No ☐ N/A | Nursing: ☐ Yes ☐ No | Taking birth control pills: ☐ Yes ☐ No

Place a check (✓) in the box next to any problems you currently have or have experienced in the past:

- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints/Pins etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormalities
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Coughing Up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

If you checked any boxes in the Medical History section (on page 2), please provide additional details below. Include the date of diagnosis, how the condition is being managed (medication or other treatments), your current level of control, and the name of your treating physician or specialist.

List any Medications you are currently taking & the correlating diagnosis:

Allergies:

Authorization and Release:

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health status, medications, or allergies.

I certify that I, and/or my dependent (s), have insurance coverage with: _____ (*Name of Insurance Company(ies)*) and assign directly Dr. Orffa Masso, DDS 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please Print Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient