Welcome
Welcome
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Welcome To Danoff Dental and Associates, LLP

PATIENT INFORMATION

Date ____________

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name ____________ M.I.____ Last Name ____________ Nickname ____________

Sex: ❑ Male ❑ Female Birth Date ____________ Age ____ Soc. Sec. # ____________ E-mail ____________

Street ____________ City ____________ State ____ Zip ____________

Home Tel.(____) ____________ Cell.(____) ____________ Have you ever been a patient of our practice? ❑ Yes ❑ No

Medical Doctor ____________ Referred By ____________

Driver's Lic.# ____________ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Employer ____________ Bus. Tel.(____) ____________

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

Who will be responsible for your account?

(If self, skip to next section) ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other ____________

Name ____________ S.S.# ____________ Birth Date ____________ Age ____ Tel.(____) ____________

Street ____________ City ____________ State ____ Zip ____________

Employer ____________ Bus. Tel.(____) ____________

Spouse or other guarantor information (*if different from above*)

Name ____________ Relation ____________ S.S.# ____________ Birth Date ____________

Street ____________ City ____________ State ____ Zip ____________

Tel. (____) ____________ Employer ____________ Bus. Tel.(____) ____________

INSURANCE INFORMATION

Student: ❑ Full Time ❑ Part Time ❑ Not School Name/Address ____________

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ____________

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY INSURANCE COMPANY

Insurance Type: ❑ **Dental** ❑ **Medical** **Employer** ____________

Bus. Address ____________ Bus. Tel.(____) ____________ Plan ____________

Ins. Co. Name ____________ Address ____________

Tel.(____) ____________ **Group #** ____________ **Group Name** ____________

Insured Party ____________ Relation ____________ Sex: ❑ M ❑ F Birth Date ____________

Address ____________ Tel.(____) ____________

S.S. # ____________ I.D. # ____________

DENTAL INFORMATION

Reason for today's visit: ____________ Are you in pain? ❑ Yes ❑ No, For How Long? ____________

Please indicate any of the following current, or prior, problems or treatments by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Red, swollen, or bleeding gums
❑ A removable dental appliance
❑ Blisters / sores in or around the mouth
❑ Prolonged bleeding from an injury / extraction
❑ Recent infections or sore throat
❑ Dissatisfaction with appearance of teeth
❑ Lost / broken filling(s)
❑ Teeth grinding / clenching
❑ Ringing in ears
❑ Broken / chipped tooth
❑ Gum disease
❑ Snoring / sleep apnea
❑ Periodontal disease
❑ Stained teeth
❑ Locking jaw
❑ Jaw pain
❑ Bad breath
❑ Burning tongue / lips
❑ Toothache
❑ Orthodontic treatment
❑ Difficulty in chewing
❑ Difficulty closing jaw
❑ Difficulty opening jaw
❑ Loose / shifting teeth
❑ Food caught between teeth
❑ Swelling / lumps in mouth
❑ Anxiety of dental treatment

❑ Other: ____________

My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting ❑ None of the listed items ❑ Other:

Last dental exam ____________ Last dental x-rays ____________ Times a day you brush? ____ Times a week you floss? ____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) What type of tooth bristles do you use? ❑ Soft ❑ Medium ❑ Hard

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ No Height ____________ Weight __________ Are you under the care of a physician? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

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

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Asthma	❑	❑	Bleeding tendency	❑	❑	Arthritis / Joint disease
❑	❑	Mitral valve prolapse	❑	❑	Hay fever / Sinus problems	❑	❑	Jaundice / Liver disease	❑	❑	Artificial joints or prosthesis
❑	❑	Heart murmur	❑	❑	Snoring / Sleep apnea	❑	❑	Hepatitis	❑	❑	Osteoporosis / Osteopenia
❑	❑	High blood pressure	❑	❑	Respiratory problems	❑	❑	Infectious mononucleosis	❑	❑	Osteonecrosis
❑	❑	Low blood pressure	❑	❑	Tuberculosis	❑	❑	Gallbladder trouble	❑	❑	Stomach ulcers
❑	❑	Chest pain / Angina	❑	❑	Emphysema	❑	❑	Fainting spells	❑	❑	Contagious diseases
❑	❑	Heart attack(s)	❑	❑	Do you smoke	❑	❑	Convulsions / Epilepsy	❑	❑	Delay in healing
❑	❑	Irregular heart beat	❑	❑	Do you use chewing tobacco	❑	❑	Stroke	❑	❑	Anemia
❑	❑	Circulatory problems	❑	❑	Blood transfusion	❑	❑	Thyroid trouble	❑	❑	Tumor or growth
❑	❑	Cardiac pacemaker	❑	❑	Blood disorder	❑	❑	Diabetes	❑	❑	Cancer
❑	❑	Heart surgery	❑	❑	Bruise easily	❑	❑	A history of alcohol abuse	❑	❑	Radiation / Chemotherapy
❑	❑	Bronchitis / Chronic cough	❑	❑	A history of drug abuse	❑	❑	Sexually transmitted diseases	❑	❑	Are you on a diet
❑	❑	Chronic fatigue / Night sweat	❑	❑	Eye disease / Glaucoma	❑	❑	Swollen ankles	❑	❑	Contact lenses
❑	❑	Mental health problems	❑	❑	Abnormal bleeding	❑	❑	Malignant hyperthermia	❑	❑	Immune system problems
❑	❑	Artificial heart valves	❑	❑	Problems w/ immune system? (possibly from med. / surg.)	❑	❑	Low blood sugar	❑	❑	Joint replacement or pins
❑	❑	Are you immunosuppressed? (possibly from transplant surg.)				❑	❑	Kidney trouble			
			❑	❑	HIV / AIDS	❑	❑	Are you on dialysis			

Is there any disease or condition not listed above that you think we should know about? ________________________________

____

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Have you ever taken diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
❑	❑	Blood thinners (Aspirin Coumadin, Warfarin, Advil)									
❑	❑	Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)									
❑	❑	MAO Inhibitors									

Please list all 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		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Sodium pentothal
❑	❑	Valium or other tranquilizers	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	NSAIDS (ibuprophen)	❑	❑	Metals	❑	❑	Sulfites	❑	❑	Amoxicillin

Please list any other medication 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 payable by your insurance company prior to completion of any dental procedure. This method of payment will be accepted only after obtaining pre-authorization of treatment and payments to be made by the insurance company.

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

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