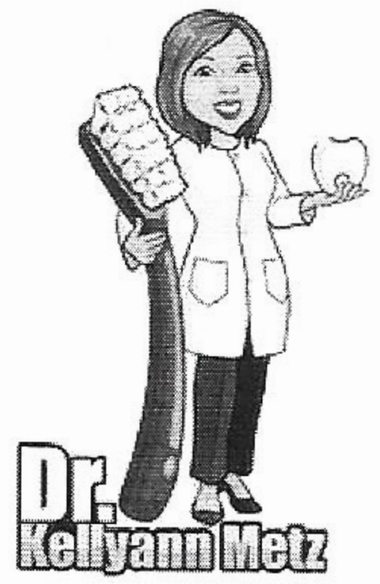
Welcome



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

NEW PATIENT INFORMATION

Date_____ Soc.Sec.#_____ Birthdate_____

Name_____ Cell Phone_____
Last Name First Name Initial

Do we have your permission to contact you by text message and or email? Yes ☐ No ☐

Address_____ Home Phone_____

City_____ State_____ Zip_____ E-mail_____

Sex: ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married

Employer_____ Business Phone_____

Business Address_____ Occupation_____

Who should we thank for referring you?_____

Emergency Contact_____ Phone _____

DENTAL INSURANCE

Person Responsible for Account_____ Insurance Company _____

Relationship to Patient_____ Birthdate_____ Soc.Sec.#_____

DENTAL HEALTH

Reason for today's visit:_____

Have you ever had any serious problems associated with previous delta treatment? Yes ○ Or No ○
If so, explain:_____

MEDICAL HISTORY

Name of Physician _____ Last complete physical?_____

Have you ever been hospitalize? Yes ○ or No ○ — Reason: _____

(WOMEN) ○ ○

Are you pregnant? Yes or No. If yes, how long? _____

PLEASE ADD ANYTHING IMPORTANT:_____

Please list all the medication you are taking: _____

Have you ever been treated for: (Check Yes or No)

Heart Disease	○	○	Hay Fever	○	○
Rheumatic Fever	○	○	Sinus Trouble	○	○
Heart Murmur	○	○	Mental Illness	○	○
Hight Blood Pressure	○	○	Arthritis	○	○
Diabetes	○	○	Stroke	○	○
Tuberculosis or lung disease	○	○	Glaucoma	○	○
Ulcers	○	○	Kidney Disease	○	○
Epilepsy	○	○	Hepatitis (Kidney Disease)	○	○
Anemia	○	○	HIV (AIDS)	○	○
Asthma	○	○	Other, explain	○	○
	Yes	**No**		**Yes**	**No**

Are you allergic to: (Check Yes or No)

	Yes	**No**		**Yes**	**No**
Penicillin	○	○	Are you subject to prolonged bleeding?	○	○
Codeine	○	○	Are you subject to fainting spells?	○	○
Local injected anesthetics	○	○	Do you have excessive urination and/or thirst?	○	○
			Do you have a pacemaker?	○	○
Other: Please list			Do you smoke?	○	○
			Do you wear contact lenses, hearing aid or any prosthetic device?	○	○

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to **ANDREA MATTIA DDS** for all insurance benefits otherwise payable to me for service 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 **ANDREA MATTIA DDS** to release the information required to secure the payment of benefits. I authorize the use of my signature in all insurance submissions.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian if patient is a minor Date