

PATIENT INFORMATION

Please fill out entire form
(PLEASE PRINT)

DATE _____ HOME PHONE _____
 EMAIL ADDRESS _____

PATIENT'S NAME _____
 Last Name MI First Name Preferred Name / Nickname

IF PATIENT IS A MINOR, GIVE PARENT OF GUARDIANS NAME: _____

SEX: Male Female BIRTHDATE _____ AGE _____ Single Married Separated Divorced Widowed Minor

RESIDENCE- STREET _____ CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____ OCCUPATION _____ HOW LONG _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____ EXT _____

SPOUSE NAME _____ SPOUSE EMPLOYED BY _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ RELATION TO PATIENT _____

PATIENT SOCIAL SECURITY # _____ PATIENT DRIVERS LICENSE # _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____ PHONE _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

IMPORTANT CONTACT NUMBERS

Please provide a telephone number we may call to confirm your appointments, or any other messages regarding treatment.

(____) _____ - _____ (____) _____ - _____ (____) _____ - _____
 HOME WORK CELL

DENTAL BENEFITS 1ST COVERAGE

EMPLOYEE NAME _____
 EMPLOYEE BIRTHDATE _____
 EMPLOYER _____
 INSURANCE CO. _____
 ADDRESS _____
 TELEPHONE _____
 GROUP NAME/NUMBER _____
 SOCIAL SECURITY # _____
 ID # _____

DENTAL BENEFITS 2ND COVERAGE

EMPLOYEE NAME _____
 EMPLOYEE BIRTHDATE _____
 EMPLOYER _____
 INSURANCE CO. _____
 ADDRESS _____
 TELEPHONE _____
 GROUP NAME/NUMBER _____
 SOCIAL SECURITY # _____
 ID # _____

GENERAL CONSENT & RELEASE

I, the undersigned, understand that I am responsible for all charges whether or not paid by insurance, if applicable. I may or may not have DENTAL insurance and, if so, assign directly to Andres Torres, D.D.S, M.S.D. all benefits, if any, otherwise payable to me for services rendered. 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 my insurance submissions whether manual or electronic. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my health care, advice and treatment to another dentist, dental specialist, or physician.

DATE _____ PATIENT SIGNATURE _____ (If patient is a minor, parent or legal guardian sign)

PATIENT HEALTH HISTORY

PHYSICIANS'S NAME _____ TELEPHONE _____

LAST PHYSICAL EXAM _____

HAVE YOU EVER HAD OR DO HAVE:

None of the below

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Frequent Headaches / Migraines | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers, Stomach Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Arthritis/Lupus |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma or Lung Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Hemophilia/Bleeding |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Joint Placement |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Special Diet Drugs | <input type="checkbox"/> Stint Placement |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Other: _____ |

DO YOU SMOKE, CHEW, USE SNUFF OR ANY OTHER FORM OF TOBACCO? YES NO

HOW MUCH? _____ A DAY.

HAVE YOU EVER HAD A SERIOUS ILLNESS OR MAJOR SURGERY OR BEEN HOSPITALIZED? YES NO

If so, explain: _____

ARE YOU PREGNANT, POSSIBLE PREGNANT OR NURSING? YES NO

**(OFFICE USE ONLY)
COMMENTS**

BLOOD PRESSURE: _____

PULSE: _____

Has there been any changes in your health history?

Date _____

Signature _____

Doctor Initials _____

Has there been any changes in your health history?

Date _____

Signature _____

Doctor Initials _____

PATIENT ALLERGIES & MEDICATIONS

ALLERGIES

NONE Local Anesthetics _____

LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO OR HAD A REACTION TO

Penicillin _____

Other Antibiotics _____

Codeine or Other Narcotics _____

Other Medications _____

Latex or Metals _____

MEDS

NONE

ARE YOU OR HAVE YOU EVER TAKEN ACTONEL, AREDIA, BONIVA, FOSAMAX, ZOMETA, OR ANY OTHER MEDICATION FOR OSTEOPEROSIS? YES NO

LIST ANY MEDICATIONS, SUBSTANCES, HOMEOPATHIC SUPPLEMENTS, HERBS, OR PILLS YOU ARE NOW TAKING

**(OFFICE USE ONLY)
COMMENTS**

Doctor Initials _____

PATIENT DENTAL HISTORY

Purpose of Initial Visit _____

How long since your last visit? _____

Previous Dentist's Name _____ City _____

CIRCLE THE APPROPRIATE ANSWER

- | | | |
|---|-----|----|
| Have you made regular visits? | YES | NO |
| Have you lost any teeth or have any been removed? | YES | NO |
| Do you hurt if you clench or grind your teeth? | YES | NO |
| Does your jaw click or pop? | YES | NO |
| Do you have pain in your jaw or near your ears? | YES | NO |
| Do your gums bleed or hurt? | YES | NO |
| Have you ever had gum treatment or periodontal surgery? | YES | NO |
| Are you unhappy with the appearance of your teeth? | YES | NO |
| Have you had any orthodontic treatment? | YES | NO |
| Is there anything about dentistry that you strongly dislike? | YES | NO |
| Have you ever had any problems or complications with previous dental treatment? | YES | NO |

If yes, explain: _____
Are any of your teeth sensitive to: Hot Cold Sweets Pressure

**(OFFICE USE ONLY)
COMMENTS**

Doctor Initials _____

Date _____ Signature _____ If patient is a minor, parent or legal guardian sign

