Patient Information (Confidential)

Today's Date ____________________

Name ________________________________ *Birthdate* ____ / ____ / _____ *Social Security #* _____ - _____ - ______

Address ________________________________ *Apt #* _____ *City* __________________ *State* _____ *Zip* _________

Home Phone ____________________ *Cell Phone* ____________________ *Work Phone* ______________________

Please Circle: *Minor* *Single* *Married* *Divorced* *Widowed* *Separated*

Name of Person to Contact in Case of an Emergency ____________________________ *Phone #* __________________

Financial Responsible Party *(or parent if minor)*

Name of Person Responsible for this Account ________________________________ *Relationship to Patient* ________________

Birthdate _____ / _____ / _____ *Social Security #* _____ - ___ - _____

Address __________________________________ *Apt #* ____ *City* ________________ *State* _____ *Zip* __________

Home phone ______________________ *Cell Phone* _______________ *Work Phone* _______________ *Ext.* ______

Dental *Insurance Information*

Name of Insured ____ *Relationship to Patient* ________________

Birthdate _____ / _____ / _____ *Social Security #* ______ - ____ - ______

Name of Employer ____ *Work Phone* _______________ *Ext.* ______

Address of Employer ________________________________ *City* __________________ *State* ______ *Zip* _______

Insurance Company ________________________________ *Group #* __________ *Policy/ID #* ________________

Insurance Co. Address ______________________________ *City* _________________ *State* ______ *Zip* ________

Medical *Insurance Information*

Name of Insured ____ *Relationship to Patient* ________________

Birthdate _____ / _____ / _____ *Social Security #* ______ - ____ - ______

Name of Employer ____ *Work Phone* __________ *Ext.* ______

Address of Employer ________________________________ *City* __________________ *State* ______ *Zip* _______

Insurance Company ________________________________ *Group #* __________ *Policy/ID #* ________________

Insurance Co. Address ______________________________ *City* _________________ *State* ______ *Zip* ________

DO YOU HAVE ANY ADDITIONAL COVERAGE? ☐ ***Yes*** ☐ ***No*** ***IF YES, ASK FOR SECONDARY INSURANCE SHEET***

We are proud to welcome new patients to our office and would like to know who referred you? ______________________

Physician ____ *Dentist* ____ *Other* ____ *Name of Dentist* _________________ *Name of Physician* ___________________

Name of Pharmacy __________________ *Address* __________________________ *Phone Number* _____________

Please complete the opposite side of the page. Thank you.

Patient Medical History

Height ____________ *Weight* ____________ *Sex* ______

Do you have or ever had any of the following ***(check only those that apply*** *– leave others blank):*

_____ *Heart Murmur*
_____ *Heart Disease*
_____ *Heart Valve Problem*
_____ *Chest Pain*
_____ *Rheumatic Fever*
_____ *Epilepsy, Seizures*
_____ *Diabetes*
_____ *High Blood Pressure*
_____ *Anemia*
_____ *Sickle Cell Anemia*

_____ *Bleeding Disorder*
_____ *Hepatitis, Liver Disease*
_____ *Tuberculosis, Lung Disease*
_____ *Asthma*
_____ *Hay Fever*
_____ *Sinus Trouble*
_____ *Kidney Disease*
_____ *Thyroid or other Gland Disease*
_____ *Ulcers*
_____ *Strong Gag Reflex*

_____ *Arthritis*
_____ *Stroke*
_____ *Malignancy, (Cancer)*
_____ *Mental Illness*
_____ *Nerve/Muscle Disease*
_____ *TMJ Problems*
_____ *Facial Fractures*
_____ *Venereal Disease*
_____ *Stomach/Intestine Disease*

Any other health problems? ____

Have you ever had surgery? _______ *When?* _________________ *For?* ______________________________

Were you ever hospitalized for anything else? ______________ *What?* _________________________ *When?* __________________

Have you ever had general anesthetic? ________________ *When?* __________________ *Any problems?* ______________________

Have you ever had any pins, rods, plastic joints, shunts or valves permanently inserted into your body? ________________________

Are you pregnant? _______ *Are you nursing?* _______ *Do you smoke, vape, chew?* __________ *How often?* ________________

Do you drink alcohol? ________________ *How much?* ____________________ *How often?* ________________________________

Do you have any pain or discomfort in your mouth currently? _____ *Do you feel nervous about having dental treatment?* _________

Medications

Are you taking any of the following medications for Osteoporosis or Bone metastases (Please Circle):

FOSAMAX ACTONEL BONIVA AREDIA ZOMETA RECLAST

Please list medications / vitamins / herbs you take daily:

____

____

____

Allergies (Please Circle)

NKDA (No Known Drug Allergies) ASPIRIN PENICILLIN CODEINE SULFA IODINE/SHELLFISH LATEX

Any other allergies?

____

Authorization and Release for Patient HIPPA Privacy and Financial Responsibilities.

I certify that I have read and understand the above information to the best of my knowledge and that all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. We support your right to the privacy of your health information. We disclose your health information for treatment, payment or where applicable by federal and state law. I authorize Dr. Cecere to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during under his care to third party payers, health practitioners, family, friend or other person to the extent necessary to help with healthcare or with payment for your healthcare. I authorize and request my insurance company to pay directly to Dr. Cecere insurance benefits otherwise payable to me. I understand that my dental/medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that I may be charged a 1.5% per month if my balance goes beyond 30 days.

X____ Date ____________________

Signature of patient (or parent if minor)

Doctors Signature ____ Date____________________