W E L C O M E

Patient Information

Date: ______________________
Name: ______________________
Address: ______________________
City: ______________ State: ________ Zip Code: ________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________
eMail:

Birth Date:	Sex: M ___ F___	Marital Status: Single Married Divorced Minor
Social Security #:	Employer/School:	
Spouse's Name:	Spouse's Phone#:	
Emergency Contact:	Phone #:	
Who Referred You:		

Dental Insurance

Who is responsible for this account?	Relationship :
Insurance Company:	Group #:
Insurance ID #:	Are You Covered by a Second Insurance: Yes No
Second Insurance Company:	Group #:
Insurance ID #:	Subscribers name:

I certify that I and/or my dependant(s), have insurance coverage and assign directly to Dr Tania Florez, 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. I hereby acknowledge and agree that any account that becomes delinquent will be subject to collections service. I agree to pay all court costs and reasonably attorney fees for collection of all past due amounts owed, plus interest thereon at 18% per annum on all such amounts outstanding. I understand that an insufficient funds check service charge of $20 will be assessed on all returned checks.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance companies 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 my current treatment plan is completed or one year from the date signed.

Signature:	Date:

Dental History

Former Dentist:	Date of Last visit:

Circle "Y" (yes) or "N" (no) to indicate if you have had any of the following:

Bad Breath	Y	N	Foreign Objects	Y	N	Periodontal treatment	Y	N
Bleeding Gums	Y	N	Grinding Teeth	Y	N	Sensitivity to cold	Y	N
Blisters	Y	N	Gums swollen or tender	Y	N	Sensitivity to heat	Y	N
Burning Sensation	Y	N	Jaw pain or tiredness	Y	N	Sensitivity to sweets	Y	N
Chew on one side	Y	N	Lip or cheek biting	Y	N	Sensitivity when biting	Y	N
Cigar/Cigarette Smoking	Y	N	Loose teeth/bkn fillings	Y	N	Sores/growth in your mouth	Y	N
Clicking or Popping Jaw	Y	N	Mouth breathing	Y	N			
Dry Mouth	Y	N	Mouth pain, brushing	Y	N	How often do you floss?		
Fingernail Biting	Y	N	Orthodontic treatment	Y	N	How often do you brush?		
Food between teeth	Y	N	Pain around ear	Y	N			

Health History

Physcian's Name:	Physcian's Phone #:

Circle "Y" (yes) or "N" (no) to indicate if you have had any of the following:

AIDS/HIV	Y	N	Epilepsy	Y	N	Radiation Treatment	Y	N
Anemia	Y	N	Fainting or dizziness	Y	N	Respiratory Disease	Y	N
Arthritis, Rheumatism	Y	N	Glaucoma	Y	N	Rheumatic Fever	Y	N
Artificial Heart Valves	Y	N	Headaches	Y	N	Scarlet Fever	Y	N
Artificial Joints	Y	N	Heart Murmur	Y	N	Shortness of Breath	Y	N
Asthma	Y	N	Heart Problems	Y	N	Sinus Troubles	Y	N
Back Problems	Y	N	Hepatitis Type _____	Y	N	Skin Rash	Y	N
Bleeding abnormally with extractions or surgery	Y	N	Herpes	Y	N	Special Diet	Y	N
Blood Disease	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Jaundice	Y	N	Swollen Feet or Ankles	Y	N
Chemical Dependency	Y	N	Jaw Pain	Y	N	Swollen Neck Glands	Y	N
Circulatory Problems	Y	N	Kidney Disease	Y	N	Thyroid Problems	Y	N
Congenital Heart Lesions	Y	N	Liver Disease	Y	N	Tonsillitis	Y	N
Cortisone Treatments	Y	N	Low Blood Pressure	Y	N	Tuberculosis	Y	N
Cough, persistent or bloody	Y	N	Mitral Valve Prolapse	Y	N	Tumor or growth on head or neck	Y	N
Dental Anxiety	Y	N	Nervous Problems	Y	N	Ulcer	Y	N
Diabetes	Y	N	Psychiatric Care	Y	N	Venereal Disease	Y	N
Emphysema	Y	N	Do you wear contact lenses?	Y	N	Weight Loss, unexplained	Y	N

Have you been told to take any medication prior to dental treatment? Y N

Women Only:

Are you pregnant? Y N Due date: ____________________ Are you nursing? Y N

Taking birth control pills Y N

Parents Only: Would you like your child to have Fluoride Treatment? Y N

Allergies:

Aspirin	Y	N	Iodine	Y	N	Local Anesthetic	Y	N
Barbituates	Y	N	Latex	Y	N	Penicillin	Y	N
Codiene	Y	N	Jewelry	Y	N	Sulfa	Y	N
Tetracycline	Y	N	Other:					

Medications:

List any medications you are currently taking and the correlating diagnosis:

Do take any BisPhos Drugs such as Boniva or FosaMax? Y N Type:

Pharmacy:	Pharmacy Phone #:

Thank You for completing this form!