2 sides

PATIENT INFORMATION (CONFIDENTIAL)

DATE ____________

Patient's Name ____________ Birthdate ____________
Address ____________ City ____________ State ________ Zip ________
Home Phone ____________ Work Phone ____________ Cell Phone ____________
E-Mail Address ____________
Social Security # ____________ Employer ____________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If College Student ☐ Full Time ☐ Part Time # Of Units ______ Name of School ____________
Person To Contact In Case Of Emergency ____________ Phone ____________
Whom May We Thank For Referring You ____________

RESPONSIBLE PARTY

Name Of Person Responsible For This Account ____________ Relationship to Patient ____________
Address ____________ Home Phone ____________
Social Security # ____________ Driver's License # ____________ Birthdate ____________
Employer ____________ Work Phone ____________
Is This Person Currently A Patient In Our Office? ☐ Yes ☐ No

INSURANCE INFORMATION

Insured: ☐ Self ☐ Parent ☐ Spouse
If Other Than Self:
Name Of Policy Holder (Insured) ____________
Name of Employer ____________
Date Of Birth ____________ Social Security # ____________

Name Of Insurance Co. ____________ Group ____________
Ins. Co. Address ____________ City ____________ State ________ Zip ________
Do You Have Additional Insurance? ☐ Yes ☐ No If Yes, Complete The Following:
Insured: ☐ Self ☐ Parent ☐ Spouse
If Other Than Self:
Name Of Policy Holder (Insured) ____________
Name of Employer ____________
Date Of Birth ____________ Social Security # ____________
Name Of Insurance Co. ____________ Group ____________
Ins. Co. Address ____________ City ____________ State ________ Zip ________

Consent For Treatment: I certify that all questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me, or my child, to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I herby give permission to Robert A. Sowins, D.D.S. and Andrew W. Gotelli, D.D. S. and staff to administer treatment and to use anesthetics necessary to perform such procedures that may be needed or advisable for diagnosis and treatment. I have received a copy of this office's Notice of Privacy Practices, their Financial Policy, and a Dental Materials Fact Sheet, as required by law.

YOUR SIGNATURE BELOW SIGNIFIES YOUR UNDERSTANDING AND WILLINGNESS TO COMPLY WITH THESE POLICIES.

Signature ____________

If Minor, Parent or Guardian

COS 070

REGISTRATION

PATIENT DENTAL HISTORY

What is the Reason for Today's Visit? ______

When Was Your Last Dental Visit? ______ Reason? ______

Name of Previous Dentist ______ City ______ State ______

How Long Since a Set of Full Mouth Xrays Were Taken? ______ Where? ______

What Kind of Toothbrush Do You Use? ______

Have You Ever Had Periodontal Treatment or Surgery? ______

Do You Have Sensitive Teeth? ______ To What? ______

Are You Apprehensive About Dental Treatment? ______

	Yes	No
Do Your Gums Bleed While Brushing or Flossing?	☐	☐
Do You Have any Sores or Lumps in or Near Your Mouth?	☐	☐
Are You Subject to Bad Breath?	☐	☐
Have You Ever Had Any Head, Neck or Jaw Injuries?	☐	☐
Are you Aware of Grinding or Clenching Your Teeth?	☐	☐
Do You Have Headaches, Earaches, Jaw or Neck Pains?	☐	☐
Have You Noticed any Loosening of Your Teeth?	☐	☐
Have You Ever Worn a Bite Plate or Night Guard?	☐	☐
Have You Worn Braces on Your Teeth?	☐	☐
Do You Wear Dentures or Partials?	☐	☐

If You Could Change Anything About Your Smile, What Would You Change? ______

MEDICAL HISTORY

Do you have or have you had:	YES	NO		YES	NO	Are you allergic or sensitive to:	YES	NO
High Blood Pressure	☐	☐	Arthritis or Rheumatism	☐	☐	Local Anesthetic	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Penicillin	☐	☐
Heart Trouble	☐	☐	Breathing Problems	☐	☐	Erythromycin	☐	☐
Heart Attack	☐	☐	Sinus Trouble	☐	☐	Clindamycin	☐	☐
Heart Murmur	☐	☐	Subject to Fainting/Dizziness	☐	☐	Aspirin	☐	☐
Defective Heart Valve	☐	☐	Epilepsy or Seizures	☐	☐	Codeine	☐	☐
Angina	☐	☐	Hives or Skin Rash	☐	☐	Metals (nickel,mercury)	☐	☐
Pacemaker	☐	☐	Allergies/Hay Fever	☐	☐	Sulfa Drugs	☐	☐
Stroke	☐	☐	Nervousness	☐	☐	Latex	☐	☐
Rheumatic Fever	☐	☐	Herpes	☐	☐	Other ______	☐	☐
Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Do you smoke or use Tobacco?	☐	☐
Kidney or Liver Disease	☐	☐	Aids or HIV Infection	☐	☐	Past use or current use of Fosamax	☐	☐
Hepatitis	☐	☐	Thyroid Disorder	☐	☐	**Women Only:**		
Type ______			Stomach Ulcer	☐	☐	Are you pregnant?	☐	☐
Tuberculosis	☐	☐	Radiation Therapy	☐	☐	Are you nursing?	☐	☐
Tendency to prolonged bleeding			Cancer	☐	☐	Are you taking birth control pills?	☐	☐
when cut or injured	☐	☐	Chemical/Alcohol Dependency	☐	☐			

What is your current Health status? ______

Are you now under a physician's care? ______ If yes, for what? ______

Physician's name ______ Telephone ______

List any surgeries or joint replacements ______

List any medications you are taking ______

List any over the counter medications or herbal supplements you are taking: ______

______