



PATIENT INFORMATION

Name: _____

TODAY'S DATE: _____

Address: _____

Sex : Female Male

City, State, ZipCode _____

Marital Status: Married

Nickname: _____

Single Divorced Widowed

Home Phone: _____

SS#: _____

Work Phone: _____

Birthdate: _____

Cell Phone: _____

Your E-mail: _____

I was referred to Z dentistry by: Friend _____ Yelp YP.com Angies List
 Insurance Co. Z dentistry Website Driving By CareCredit Other _____

INSURANCE INFORMATION

Insured Person's Relationship to You: Self Spouse Child

** Skip to Dental History if you are the insured person

Insured Person's Name: _____

Home Phone: _____

Address: _____

Cell Phone: _____

City, State, ZipCode _____

SS#: _____

Employment Status: Full Time Part Time Retired

Birthdate: _____

Employer Name: _____

Sex : Female Male

Dental Insurance Company: _____

DENTAL HISTORY

Former Dentist: _____ **Date of last dental X-rays:** _____ **Date of last dental care:** _____

- | | | |
|--|--|--|
| <input type="radio"/> I like my teeth | <input type="radio"/> My gums bleed | <input type="radio"/> My teeth are sensitive |
| <input type="radio"/> I like the color of my teeth | <input type="radio"/> I have loose teeth | <input type="radio"/> I grind or clench my teeth |
| <input type="radio"/> I do not get cavities | <input type="radio"/> I often have bad breath | <input type="radio"/> My jaw clicks or pops |
| <input type="radio"/> Food collects between my teeth | <input type="radio"/> I have had periodontal treatment | <input type="radio"/> I have sores/growths in my mouth |

How long do you plan to keep your teeth? _____

How often do you brush?

How often do you floss?

MEDICAL HISTORY

Physician: _____ Physician's Phone Number _____

Please list any medications you are taking. _____**Have you had a surgery in the last 12 months?** Yes No

Type: _____

I Have The Following Allergies: **No Known Allergies**

- | | | | |
|--|------------------------------------|------------------------------------|---|
| <input type="radio"/> Aspirin | <input type="radio"/> Erythromycin | <input type="radio"/> Metals | <input type="radio"/> Others (please list): |
| <input type="radio"/> Codeine | <input type="radio"/> Jewelry | <input type="radio"/> Penicillin | |
| <input type="radio"/> Dental Anesthetics | <input type="radio"/> Latex | <input type="radio"/> Tetracycline | |

I Smoke or Use Tobacco Products: Yes No**For Women Patients:**Do you take birth control pills? Yes NoAre you pregnant? Yes No

How many weeks pregnant are you? _____

Are you nursing? Yes No**Please check any of the following conditions that you have.**

- | | | | | | |
|--|---|--|--|--|---------------------------------------|
| <input type="radio"/> Abnormal Bleeding | <input type="radio"/> Chemotherapy | <input type="radio"/> Fainting Spells | <input type="radio"/> I Need to Pre-Medicate with Antibiotics | <input type="radio"/> High Blood Pressure | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Alcohol/Drug Abuse | <input type="radio"/> Colitis | <input type="radio"/> Fever Blisters | <input type="radio"/> Kidney Problems | <input type="radio"/> Liver Disease | <input type="radio"/> Shingles |
| <input type="radio"/> Anemia | <input type="radio"/> Congenital Heart Defect | <input type="radio"/> Frequent Headaches | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Lung Problems | <input type="radio"/> Stroke |
| <input type="radio"/> Angina Pectoris | <input type="radio"/> Cosmetic Surgery | <input type="radio"/> Glaucoma | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Osteoporosis | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Arthritis | <input type="radio"/> Diabetes | <input type="radio"/> HIV+ AIDS | <input type="radio"/> Pace Maker | <input type="radio"/> Psychiatric Conditions | <input type="radio"/> Ulcers |
| <input type="radio"/> Artificial Bones | <input type="radio"/> Difficulty Breathing | <input type="radio"/> Heart Attack/Heart Disease | <input type="radio"/> Radiation Therapy | <input type="radio"/> Venereal Disease | |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Drug Abuse | <input type="radio"/> Heart Surgery | | | |
| <input type="radio"/> Asthma | <input type="radio"/> Eating Disorder | <input type="radio"/> Hemophilia | | | |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Emphysema | <input type="radio"/> Hepatitis | | | |
| <input type="radio"/> Cancer | <input type="radio"/> Epilepsy | | | | |

I understand that I am responsible for all charges whether or not I have insurance. The information I have given above is accurate to the best of my knowledge.

Signature _____ Date _____

Please print your name

AUTHORIZATION TO BILL INSURANCE

I certify that I, and/or my dependent(s) have insurance coverage and that I assign all insurance benefits directly to Dr. George A. Zatarain. I authorize Z dentistry to release any information to my insurance company(ies) and their agents necessary to secure the payment of benefits.

Signature _____ Date _____

Please print your name