PATIENT INFORMATION

Name: ____ **TODAY'S DATE: ____________**

Address: ____ Sex : O Female O Male

City, State, ZipCode ______________________________________ Marital Status: O Married

Nickname: ____ O Single O Divorced O Widowed

Home Phone: ____ SS#: _____________________

Work Phone: ____ Birthdate:___________________

Cell Phone: Your E-mail:

I was referred to Z dentistry by: O Friend________________________ O Yelp O YP.com O Angies List

O Insurance Co. O Z dentistry Website O Driving By O CareCredit O Other___________________________

INSURANCE INFORMATION

** If you are the insured person fill in the Employer Name and Insurance Company Only

Insured Person's Relationship to You: O Self O Spouse O Child

Insured Person's Name:____ Home Phone: ______________

Address: ____ Cell Phone: ________________

City, State, ZipCode ______________________________________ SS#: ______________________

Employment Status: O Full Time O Part Time O Retired Birthdate: __________________

Employer Name: ____ Sex : O Female O Male

Dental Insurance Company: _________________________________

DENTAL HISTORY

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

O I like my teeth
O My gums bleed
O My teeth are sensitive
O I like the color of my teeth
O I have loose teeth
O I grind or clench my teeth
O I do not get cavities
O I often have bad breath
O My jaw clicks or pops
O Food collects between my teeth
O I have had periodontal treatment
O I have sores/growths in my mouth

How long do you plan to keep your teeth? ____

How often do you floss?

How often do you brush?

MEDICAL HISTORY

Physician: ________________________________ Physician's Phone Number ____________________

Please list any medications you are taking. ____

____

____

Have you had a surgery in the last 12 months? O Yes O No

Type:____

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

O Aspirin
O Codeine
O Dental Anesthetics
O Erythromycin
O Jewelry
O Latex
O Metals
O Penicillin
O Tetracycline
O Others (please list):

I Smoke or Use Tobacco Products: O Yes O No

For Women Patients:

Are you pregnant? O Yes O No

Are you nursing? O Yes O No

Do you take birth control pills? O Yes O No

How many weeks pregnant are you? ____________

Please check any of the following conditions that you have.

O Need to Pre-Medicate	O Cancer	O Epilepsy	O High Blood Pressure	O Rheumatic Fever
O Abnormal Bleeding	O Chemotherapy	O Fainting Spells	O Kidney Problems	O Shingles
O Alcohol Abuse	O Colitis	O Fever Blisters	O Liver Disease	O Sickle Cell Disease
O Anemia	O Congenital Heart Defect	O Frequent Headaches	O Low Blood Pressure	O Sinus Problems
O Angina Pectoris	O Cosmetic Surgery	O Glaucoma	O Lung Problems	O Stroke
O Arthritis	O Diabetes	O HIV or AIDS	O Mitral Valve Prolapse	O Thyroid Problems
O Artificial Bones	O Difficulty Breathing	O Heart Attack/ Heart Disease	O Osteoporosis	O Tuberculosis
O Artificial Heart Valve	O Drug Abuse	O Heart Surgery	O Pace Maker	O Ulcers
O Asthma	O Eating Disorder	O Hemophilia	O Psychiatric Conditions	O Venereal Disease
O Blood Transfusion	O Emphysema	O Hepatitis	O Radiation Therapy	

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