Restorative & Implant Dentistry

Dr. Alan Slootsky & Dr. Joel Baez

Name: _____
Last First Middle Initial Nickname

Address:_____
Street Apt #

_____
City State Zip

Phone: Home (____)_____Spouse Name:_____

Work (____)_____How did you hear about us?_____

Mobile(____)_____Have you seen our website?_____

Email:_____ Emergency Name:_____

Employer:_____ Emergency Phone:_____

Birth Date:_____ Social Security #:_____

Dental Information:

What is the reason for today's visit?_____

Do you have any questions or concerns we can help you with?_____

When was your last dental visit?_____

What did you like/dislike about previous dentist?_____

Do you snore?_____ Does your significant other snore?_____

Have you had periodontal (gum)treatment?_____Ortho?_____ TMJ?_____

Does anyone in your family have gum/tooth problems?_____

Do you have dry mouth?_____ If yes when is it worse? Morning Day Night

Do your gums bleed?_____Are your teeth sensitive to hot or cold?_____

Do you have bumps or swelling in your mouth?_____Clicking or popping of jaw?_____

Wake up with headaches?_____Clenching or grinding_____

Insurance Information:

Subscriber Name_____Social Security #_____

DOB_____Ins Co. Name_____

Insurance Co Phone #_____Group #_____

Relationship to the patient_____Do you have any other ins coverage?_____

Insurance Authorization Statement

I understand that I am responsible for all costs and dental treatment. I hereby authorize this dental office to administer such medications and preform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature_____Date_____

Medical History and Information:

Do you have or ever had?

____ Arthritis
____ Asthma
____ Auto Immune Disorders
____ Blood Transfusion
____ Cancer
____ Diabetes
____ Epilepsy
____ Excessive bleeding when cut
____ Heart Murmur
____ Heart Problems
____ Hepatitis
____ High Blood Pressure
____ HIV Positive
____ Kidney Problems
____ Mitral Valve Prolapse
____ Osteoporosis
____ Pacemaker
____ Stroke
____ Joint Replacement If yes please list_____
____ Other_____

Are you allergic to?

____ Antibiotics if yes please list_____

List other allergies_____

Are you taking aspirin or any other blood thinners?_____

_____

What Medications are you currently taking?_____

_____

_____

Female Patients: Are you pregnant?_____

Do you take birth control?_____

Treatment Authorization:

Before treatment is rendered, adequate radiographs of the teeth and mouth must be taken. I authorize and give consent to preform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payments for all treatments and services are my responsibility.

_____ _____

Patients Signature/Legal Guardian Date