STOFFEL & TOMAZIN dental associates

Where Healthy Smiles Begin

Home Phone
Cell Phone
E-mail

Patient Information (CONFIDENTIAL)

Name			Birthdate
Address	City	State	Zip/Post Code

Check Appropriate Box:
☐ minor ☐ single ☐ married ☐ divorced ☐ widowed ☐ separated

If Student, Name of School / College	City	State	Part time or full
Patient's or Parent's Employer		Work Phone	
Business Address	City	State	Zip/Post Code
Spouse or Parent's Name	Employer		Work Phone
Whom may we thank for referring you?			
Person to contract in case of emergency		Phone	

Responsible Party

Name of Person Responsible for this account	Relationship to Patient
Address	Home Phone
Birthdate	

Dental Insurance Information

Name of Insured		Relationship to Patient	
Birthdate		Social Security #	
Name of Employer	Union of Local #	Work Phone	
Address of Employer	City	State	Zip/Post Code
Insurance Company	Group #	Policy/ID #	
Insurance Co. Address	City	State	Zip/Post Code

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No
IF YES COMPLETE THE FOLLOWING:

Name of Insured		Relationship to Patient	
Birthdate		Social Security #	
Name of Employer	Union of Local #	Work Phone	
Address of Employer	City	State	Zip/Post Code
Insurance Company	Group #	Policy/ID #	
Insurance Co. Address	City	State	Zip/Post Code

For your convenience, we offer the following methods of payment. Please check the option you prefer.
Payment is due in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ Care Credit

Patient Medical History

Are you under a physician's care now? ☐ Yes ☐ No	If yes, please explain.
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No	
Have you ever had a serious head or neck injury? ☐ Yes ☐ No	
Are you taking any medication, pills or drugs? ☐ Yes ☐ No	
Are you on a special diet? ☐ Yes ☐ No	
Do you use tobacco? ☐ Yes ☐ No	
Do you use controlled substances? ☐ Yes ☐ No	
Women: Are you pregnant/trying to get pregnant? ☐ Yes ☐ No	
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No	
Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetic ☐ Other	

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pacemaker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatment	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Patient Dental History

Name of Previous Dentist and Location:	Date of Last Exam:
Do your gums bleed while brushing or flossing? ☐ Yes ☐ No	Do you have frequent headaches? ☐ Yes ☐ No
Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No	Do you clench or grind your teeth? ☐ Yes ☐ No
Do you feel pain in any of your teeth? ☐ Yes ☐ No	Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No	Have you ever had any difficult extractions in the past? ☐ Yes ☐ No
Have you ever experienced an of the following problems in you jaw? Clicking ? ☐ Yes ☐ No Pain (joint, ear, side of face)? ☐ Yes ☐ No Difficulty in opening or closing? ☐ Yes ☐ No Difficulty in chewing? ☐ Yes ☐ No	Have you ever had any prolonged bleeding following extractions? ☐ Yes ☐ No Have you had any orthodontic treatment? ☐ Yes ☐ No Do you wear dentures or partials? If yes, date of placement ☐ Yes ☐ No Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier my payless than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____ _____

Signature of patient (or parent of patient) Date