Name (First Last): _____ **Email:** _____

Address: _____ City: _____ Postal Code: _____

Phone (best contact #): _____ Alternate #: _____ Birthday _____ (mm/dd/yyyy)

Name of parent/guardian: _____ Relationship to minor: _____

Emergency Contact (name and number) _____

Physician: _____ Referred by (pt #): _____
(name and telephone number)

****

Primary Insurance Carrier: _____ Employer: _____

GRP/Policy # _____ ID#/SIN/Cert # _____

Basic-A _____ Prosth-B _____ Cr/Br-B _____ Ortho-C _____ Limits _____

Name of Insured _____ Birthday _____ (mm/dd/yyyy)

Secondary Insurance Carrier: _____ Employer: _____

GRP/Policy # _____ SIN/Cert # _____

Basic-A _____ Prosth-B _____ Cr/Br-B _____ Ortho-C _____ Limits _____

Name of Insured _____ Birthday _____ (mm/dd/yyyy)

****

MEDICAL HISTORY (CIRCLE THE APPROPRIATE ANSWER)

1. Have you had a medical examination in the last year? Yes No
2. Have you had a serious illness or are you under the care of a physician now? Yes No
3. Do you use medication regularly? (please list all medications that you take) Yes No
   _____
   _____
4. Do you have any known allergies? Yes No
5. Are you allergic to or have you experienced any unusual reactions to any of the following? **(please circle any that apply)** Yes No
   aspirin codeine darvon tetracycline iodine
   demerol erythromycin nitrous oxide novocain sulfonamide (sulfa),
   local anaesthetic penicillin percodan metals
   barbiturates (sleeping pills) benzodiazepine (valium)
   Other _____ (medications or injections?)
6. Do you bruise easily or bleed abnormally? Yes No
   Do your gums bleed when you brush? Yes No
7. Are you on a special diet? Yes No
8. Have you ever had a blood transfusion? Yes No
9. Have you ever had an injury, surgery or x-ray therapy on your face or jaw? Yes No
10. Is there any history of family disease? (please indicate) _____ Yes No
11. Have you ever been hospitalized for any illness or operation? If yes, please explain _____ Yes No
    _____

12. Have you had or do you currently have any of the following? **(please circle all that apply)**

aids/HIV	anemia	angina	arthritis	artificial heart valve		asthma
chemotherapy	cold sores	diabetes	infectious disease		emphysema	drug addiction
epilepsy	seizures	glaucoma	jaundice	heart attack	hemophilia	hepatitis
rheumatic fever	liver disease	lung disease	tuberculosis	stroke	high or low blood pressure	
heart disease	heart murmur	venereal disease	ulcers	mental or nervous disorder		thyroid disease
kidney disease	gastrointestinal disease		steroid therapy/cortisone	blood pressure problems		
artificial joints/implants	other: _____					

13. Do you have a tendency to faint or suffer from dizzy spells? Yes No
14. Do you suffer from frequent/severe headaches? Yes No
15. Do you have a prosthetic implant? (i.e. heart pacemaker/hip prosthesis) Yes No
16. Have you had or are you at high risk for cancer? Yes No
17. Do you smoke or chew tobacco? Yes No
18. Have you been advised to take antibiotics before dental appointments? Yes No
19. Would you like to speak to the Dentist privately? Yes No
20 FOR WOMEN ONLY: Are you or could you be pregnant? (If yes, which month) _____ Yes No

DENTAL HISTORY:

1. Do you have any dental problems at present? (If yes, please provide a brief history of the condition)_____

_____

2. When was your last dental visit? _____ (mm/dd/yy) Previous dentist (for requesting x-rays) _____ (name and telephone number)
3. When did you last have dental x-rays taken? _____ (mm/dd/yy)
4. Have you had teeth extracted due to accident, decay or gum disease? (please circle all that apply)
5. Have you had crowns, fixed bridges, implant surgery, partial or full dentures? (please circle al that apply)
6. Have you had root canal treatment, orthodontic or periodontal (gum) treatment? (please circle all that apply)
7. Do you habitually: clench/grind your teeth, bite your nails or suck your thumb? (please circle all that apply)
8. Do you have any disease, condition or problem, not listed previously, that the Doctor should know about?

_____

CONSENT:

I UNDERSTAND THAT THE INFORMATION CONTAINED IN THIS DOCUMENT IS IMPORTANT FOR TREATMENT AND I CERTIFY THAT ALL OF THE INFORMATION IS CORRECT AND I HAVE NOT KNOWINGLY OMITTED ANYTHING. I AUTHORIZE THE DENTAL OFFICE TO PERFORM DIAGNOSTIC PROCEDURES, AS MAY BE REQUIRED, IN ORDER TO IDENTIFY AND/OR PERFORM TREATMENT. I UNDERSTAND THAT PAYMENT IS EXPECTED, IN FULL, AT THE APPOINTMENT THE TREATMENT IS PROVIDED.

Signature of Patient _____ (Signature of parent or guardian in case of a minor) Date: _____ (mm/dd/yyyy)

***If you have or come to have Dental Insurance your plan coverage is a contract between yourself and the company providing those benefits. As a service to our clients, we are able to bill your plan directly for most services rendered. IT IS YOUR RESPONSIBILITY TO REMIT PAYMENT TO DR. NEIL ZASTRE INC. FOR ANY BALANCE LEFT UNPAID BY YOUR INSURANCE CARRIER(S).** *PLEASE NOTE all plans do not provide the same level of benefit and benefit coverage can change periodically. Please advise us, in advance, of any changes to your plan so that we can ensure that our records are as up to date as possible. Patients are responsible for any balances not covered by your insurance provider. Your initial herein acknowledges that you accept responsibility for any balances owing for treatment provided.*

Initial _____