Welcome to our practice !

Rafael Perez, DDS * Nhi Balogh, DMD

Please take a few minutes to answer the following questions so we can better assist you with your dental needs. Thank you!

PATIENT INFORMATION

Date_____ SS#_____ Birthdate_____

Name_____ Home Phone#_____

Address_____ Cell Phone#_____

City_____ State_____ Zip_____ Email_____

Sex: M____F____Circle one: Minor Single Married Partner Divorced Separated

Employer_____ Business#_____

Business Address_____ Occupation_____

Who should we thank for referring you?_____

In case of emergency, who should we contact?_____ Phone#_____

PRIMARY DENTAL INSURANCE

Person Responsible for your account_____ Phone#_____

Relationship to patient_____ Birthdate_____ SS#_____

Address_____ City_____ State_____ Zip_____

Responsible party's employer_____ Business#_____

Business Address_____ Occupation_____

Insurance Company_____ Phone#_____

Insurance Address_____ City_____ State_____

Subscriber ID#_____ Group#_____

DENTAL HISTORY

Former Dentist_____ Date of last xrays_____

City, State_____ How often do you floss?_____

Date of last dental visit_____ How often do you brush?_____

How do you feel about your teeth?_____ Are you pleased with their appearance?_____

Circle all that apply:

Bad Breath
Bleeding Gums
Lip/Cheek Biting
Pain Around Ear
Frequent Headaches
Blisters on lips/mouth
Jaw/Head/Neck Injuries
Loose Teeth/Broken Fillings
Fingernail Biting
Sensitivity to Cold/Hot/Sweets/Chewing
Grinding/Clenching Teeth
Dry Mouth
Orthodontic Treatment
Tooth Pain

MEDICAL HISTORY

Physicians Name_____Date of last visit_____

Are you currently under medical treatment?_____

Have you ever had any serious illnesses/operations?_____

Are you currently taking any medications?_____

Do you smoke or use tobacco products?_____

Do you use alcohol or street drugs?_____

Do you wear contact lenses?_____

Have you had any allergic reactions to the following? Circle all that apply:
Local Anesthetic (novacaine) Iodine Latex Aspirin Sulfa Drugs
Barbiturates (sleeping pills) Sedatives Penicillin or other Antibiotics
Other_____

Women Only: Circle all that apply:
Pregnant Breast Feeding Taking Birth Control

Everyone: Circle all that apply:

AIDS	Back Problems	Circulatory Problems	Arthritis/Rheumatism
Anemia	Blood Disease	Excessive Thirst	Artificial Heart Valves
Asthma	Chemotherapy	Fainting/Dizziness	Chemical Dependency
Cancer	Emphysema	Frequent Urination	Chronic Fatigue Syndrome
Diabetes	Headaches	Low Blood Pressure	Congenital Heart Lesions
Epilepsy	Heart Murmur	Nervous Problems	Cortisone Treatments
Glaucoma	Heart Problems	Psychiactric Care	Artificial Joints
Herpes	HIV Positive	Radiation Treatment	Hepatitus (type)_
Jaundice	Kidney Disease	Respiratory Disease	High Blood Pressure
Jaw Pain	Liver Disease	Rheumatic Fever	Mitral Valve Prolapse
Skin Rash	Pacemaker	Shortness of Breath	Swelling of feet/ankles
Stroke	Scarlet Fever	Swollen Neck Glands	Tumor/growth on head/neck
Tonsillitis	Sinus Trouble	Thyroid Problems	Bleeding Abnormally w/extractions or surgery
Ulcer	Tuberculosis	Veneral Disease	

Other_____

Dr. use only blood pressure reading:_____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to **Stone Lake Dental** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____Date_____