PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME:_____ _____ ____ _____
(FIRST) (LAST) (MI) (Preferred name)

GENDER: ☐ Male ☐ Female **STATUS:** ☐ single ☐ married ☐ child ☐ other

SPOUSE'S NAME: _____

DATE OF BIRTH: _____/_____/_____ **Age:** _____ **SS#:** _____-- _____ -- _____
month day year

Driver's License #: _____

HOME ADDRESS: _____ **APT. #:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME #: (____) _____ **WORK #:** (____) _____ Ext. _____.

CELL #: (____) _____. **E-MAIL ADDRESS:** _____

EMPLOYER: _____ **How long have you been employed with this company?**_____

EMPLOYER'S ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____ **OCCUPATION:** _____

HOW DID YOU LEARN ABOUT OUR DENTAL OFFICE? *(Please check one of the boxes below)*

☐ Internet ☐ Driving by ☐ Phone Book ☐ Word of mouth

☐ Friend (*Name*:_____) ☐ Relative: (*Name*: _____, *relation*:_____)

EMERGENCY CONTACT

EMERGENCY CONTACT: _____ **RELATIONSHIP:**_____

HOME #: (____) _____ **WORK #:** (____) _____ Ext. _____.

CELL #: (____) _____. **OTHER #:** (____) _____.

YOUR MEDICAL DOCTOR: _____ **DOCTOR'S PHONE #:** (____) _____.

DENTAL INSURANCE (If you **do not** have dental insurance coverage, please skip to next section, pg. 3)

PRIMARY DENTAL INSURANCE

COMPANY NAME: _____ **PHONE #:** __(____)_____.

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

INSURED'S SS#: _____-- _____ -- _____ **GROUP # (Plan, Local or Policy#):** _____

INSURED'S NAME: _____ **RELATIONSHIP:** _____ **D.O.B:** ___/___/_____

INSURED'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

COMPANY NAME: _____ **PHONE #:** __(____)_____.

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

INSURED'S SS#: _____-- _____ -- _____ **GROUP # (Plan, Local or Policy#):** _____

INSURED'S NAME: _____ **RELATIONSHIP:** _____ **D.O.B:** ___/___/_____

INSURED'S EMPLOYER: _____

ROBERT M. SOLOW, D.D.S, INC. – DENTAL INSURANCE POLICES

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided
- I certify that I or my child is covered by insurance and assign directly to Dr. Robert M. Solow all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the dentist to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Guardian Date
(If patient is under 18 years of age)

YOUR DENTAL INFORMATION

REASON FOR TODAY'S VISIT: ☐ EXAM ☐ EMERGENCY ☐ CONSULTATION

Are you in pain? ☐ NO ☐ YES, How Long?_____

Do you feel nervous about having dental treatment? ☐ NO ☐ YES

If YES, explain:_____

Have you had problems with prior dental treatment or an upsetting dental experience? ☐ NO ☐ YES

If YES, explain:_____

Name of previous dentist:_____

Date of last dental exam?: _____ **Date of last dental X-rays?:** _____

ACCOUNT INFORMATION & AUTHORIZATION

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT

NAME:_____ _____ **RELATIONSHIP:** _____
(FIRST) (LAST)

SS#: _____-- _____ -- _____ **Driver's License #:** _____

BILLING ADDRESS: _____ **SUITE / APT. #:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE #: __(____)_____ **E-MAIL ADDRESS:** _____

PAYMENT METHOD: □ CASH □ CHECK □ CREDIT CARD _____ _____/_____
(CREDIT CARD #) (EXP. DATE)

CONFIDENTIAL HEALTH HISTORY

MEDICAL HISTORY **Circle appropriate answer** *(Leave blank if you do not understand the question)*

1. **Yes / No** **Is your general health good?**
   If NO, explain:_____
2. **Yes / No** **Has there been a change in your health within the last year?**
   If YES, explain:_____
3. **Yes / No** **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain:_____
4. **Yes / No** **Are you being treated by a physician now for a current medical condition?**
   If YES, explain:_____
   Date of last medical exam?_____ **Reason for exam:**_____

SYMPTOMS **Have you experienced any of the following?** *(Please circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Diarrhea	Yes / No	Jaundice
Yes / No	Fainting spells	Yes / No	constipation	Yes / No	Dry mouth
Yes / No	Unexplained weight loss	Yes / No	Frequent urination	Yes / No	Excessive thirst
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Difficulty swallowing
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Swollen ankles
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Joint pain, stiffness
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Blood in urine
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems
Yes / No	Blood in stools	Yes / No	Frequent vomiting		

CONDITIONS **Have you had or do you have any of the following?** *(Please circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Cosmetic surgery	Yes / No	Stroke
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Eating disorders
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Osteoporosis
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Thyroid disease
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Asthma
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Hepatitis (Type___)
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Sexual transmitted disease
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Herpes
Yes / No	Skin disease	Yes / No	Arthritis,rheumatism	Yes / No	Canker or cold sores
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Anemia
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Liver disease
Yes / No	Seizures			Yes / No	Eye disease
				Yes / No	Transplants

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatments for emotional condition

ALLERGIES **Are you allergic to or have you had a reaction to any of the following?**

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin/Amoxicillin	Yes / No	Percodan
Yes / No	Iodine	Yes / No	Sulfa	Yes / No	Nitrous oxide
Yes / No	Latex anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal
		Yes / No	Specific Food (Type_____)		

Others:_____

MEDICATIONS **Are you taking or have you taken any of the following in the last three months?**

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Cortico – Steroids				

Please list all medications you are currently taking:_____

WOMEN ONLY *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?**_____
Yes / No **Are you nursing?**
Yes / No **Are you taking birth control pills?**

ALL PATIENTS *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, explain:**_____

Yes / No **Have you ever been pre-medicated for dental treatment?**
If YES, why:_____

Yes / No **Have you ever taken Fen-Phen? If YES, when:**_____

Yes / No **Are you a smoker?**
If YES, how much do you smoke per day?_____**How long have you smoked?**_____

The practice of dentistry involves treating the whole person. If Dr. Solow determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize Dr. Solow to contact my physician.

Patient's Signature:_____ Date:_____

Physician's Name:_____ Office phone #:_____

ROBERT M. SOLOW, D.D.S, INC. – DENTAL PRACTICE POLICES

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my or my child's medical status. I authorize the dental staff to perform necessary dental services for me / my minor/child.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I certify that I have read and understand this Health History form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold Dr. Solow, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient Date
(Signature of Parent or Guardian if patient is under 18 years of age)