PATIENT INFORMATION

Name _____

Address _____

Telephone Numbers *Home* _____ *Work* _____

Cell _____

Patient SS # _____ Birthdate _____

Whom may we thank for referring you? _____

In case of an emergency, who should be notified? _____

Relationship _____ Telephone _____

AUTHORIZATION / RECORD RELEASE:

I authorize the release of medical/dental information, including diagnosis and records of any treatment and examination rendered to me or the above named patient, to third party payers and/or specialists regarding dental care upon my verbal consent.

Signature _____ Date _____

DENTAL INSURANCE

Name of Insured _____

Birthdate _____ SS # _____

Employer _____ Relationship to Patient _____

Insurance Co. _____ Group # _____

Do you have additional dental insurance? *Yes* ❒ *No* ❒

AUTHORIZATION / RECORD RELEASE:

I, the undersigned certify that I (or my dependent) have insurance with _____ _____ and authorize payment of dental benefits otherwise payable to me directly to Dr. Bryan G. Sicher for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

Signature of Responsible Party _____

Date _____

HEALTH HISTORY

Patient's Name _____ Birthdate _____

Physician's Name _____

Date of Late Physical Examination _____

Have you ever had, or do you presently have any of the following? (Please check boxes that apply):

- ❒ AIDS/ HIV
- ❒ Anemia
- ❒ Artificial Heart Valves
- ❒ Asthma
- ❒ Bleeding Abnormally
- ❒ Cancer
- ❒ Cardiac Transplant / Congenital Heart Defects
- ❒ Cardiovascular Disease
- ❒ Chemotherapy or Radiation Treatment
- ❒ Convulsions or Siezures
- ❒ Diabetes
- ❒ Frequent Chest Pains
- ❒ Glaucoma
- ❒ Hepatitis, Jaundice, or Liver Disease
- ❒ Heart Murmur
- ❒ Herpes
- ❒ High Blood Pressure
- ❒ History of Infective Endocarditis
- ❒ Joint Replacements/ Implants
- ❒ Kidney Disease
- ❒ Respiratory Disease or Shortness of Breath
- ❒ Stroke
- ❒ Thyroid Disease
- ❒ TB (Tuberculosis)
- ❒ Venereal Disease
- ❒ Women: Pregnant or Nursing?

Please list any disease, condition, or problem that your dentist should know before proceeding with treatment: _____

_____

Have you ever experienced any complications or illnesses following dental treatment? _____

If so please explain: _____

_____

Have you ever taken *"**Bisphosphonates**?" (Ex: Fosamax, Boniva, Actonel, Aredia, Didronel, Skelid, Sanofi-avemtis, Evista, or Zometa, Forteo)?* _____

Are you currently taking Blood Thinners? (Ex: Aspirin, Coumadin, Plavix, or Trental) _____

Have you ever used tobacco? _____ If so, how much and for how long? _____

MEDICATIONS	ALLERGIES
List any medications you are currently taking: _____ _____ _____ _____ _____	Are you allergic or have reacted adversely to: ❒ Local anesthetic ❒ Aspirin ❒ Penicillin ❒ Sulfa Drugs ❒ Codeine ❒ Barbiturates ❒ Iodine ❒ Latex ❒ Other _____

I certify that to the best of my knowledge, the above information is complete and accurate

Signature _____ Date _____