WELCOME!

ANH ZIRNSTEIN, DDS, PC
PAUL CONRAD, DDS

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Preferred _____ Social Security # _____
Last First and Middle

Address _____

City _____ State _____ Zip Code _____

Sex ☐M ☐F Age_____ Birthdate_____ Status ☐S ☐M ☐W ☐D

Phone# Home (_____)_____ Work (_____)_____

Employer _____

Email Address _____

Who referred you to our dental practice? _____

HEAD OF HOUSEHOLD AND INSURANCE INFORMATION

(Person responsible for account and/or subscriber)

Name _____ Preferred_____ Social Security #_____
Last First and Middle

Relation to Patient _____

Address _____
(If same as patient, leave blank)

City _____ State _____ Zip Code _____

Sex ☐M ☐F Age_____ Birthdate_____ Status ☐S ☐M ☐W ☐D

Phone# Home (_____)_____ Work (_____)_____

Email Address _____

Employer _____ Occupation _____
(Leave blank if same as above)

Business Address _____

City _____ State _____ Zip Code _____

INSURANCE COMPANY (CARRIER)

Name _____

Address of Carrier _____

Subscriber ID # _____ Group # _____

Name of other dependents under this plan _____

Reason for visit (Chief Complaint) _____

Payment is due in full at time of treatment, unless prior arrangements have been approved. There will be a $30.00 broken appointment fee if 24 hour notification is not given to our office.

MEDICAL HISTORY

Physicians Name _____ Phone #(_____)_____

Date of last visit _____

Are you in good health? ☐Yes ☐No

Have you had any serious illnesses or operations? ☐Yes ☐No If yes, describe _____

Are you currently under the care of a physician? ☐Yes ☐No If yes, describe _____

Have you ever had an unusual reaction to an anesthetic or drug? ☐Yes ☐No

Have you ever had trouble with prolonged bleeding after surgery? ☐Yes ☐No

For Women: Are you pregnant? ☐Yes ☐No

Taking birth control pills? ☐Yes ☐No

Please **check** if you ever had any of the following:

☐AIDS/HIV
☐Anaphylaxis
☐Asthma
☐Cortisone treatments
☐Blood disease
☐Cancer
☐Diabetes
☐Epilepsy
☐Fainting
☐Glaucoma
☐Heart murmur
☐Heart problems
Describe _____
☐Hemophilia/Abnormal bleeding
☐Hepatitis
☐High blood pressure
☐Kidney disease
☐Liver disease
☐Thyroid disease
☐Artificial heart valves
☐Artificial joints
☐Material allergies (latex)
☐Mitral valve prolapse
☐Anemia
☐Pacemaker/heart surgery
☐Rheumatic fever
☐Tuberculosis
☐Venereal disease

List any **medications** you are taking _____

List any **drug allergies** you may have _____

AUTHORIZATION

I have received the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Parent/Guardian Signature _____ Date _____