WELCOME!

ANH ZIRNSTEIN, D.D.S., P.C.

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) ____

Remarks ____

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 ______________________