SACHEM DENTAL GROUP

DATE _____

UPDATE _____

PATIENT INFORMATION

Patient _____

Patient Address _____ City _____ State_____ Zip Code _____

Home Phone: _____ Work Phone: _____ Cell: _____

Sex: ❒ M ❒ F Age _____ Birthdate _____ SS#: _____

❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced ❒ Child

Employer's Name, Address, Phone: _____

_____

If minor child, responsible party:

Name: _____ SS#: _____ Birthdate: _____

Address _____ City _____ State_____ Zip Code _____

INSURANCE INFORMATION

Is Patient covered by Insurance? ❒ YES ❒ NO

Policyholder's Name: _____ SS#: _____ Birthdate: _____

Address *(if different from patient):* _____

Relationship to Patient: _____

Insurance Company Name: _____ Group #: _____

Insured's Employer: _____ Phone #: _____

Employer's Address: _____

Is Patient Covered by Additional Insurance? ❒ YES ❒ NO *(If "YES", please continue below)*

Policyholder's Name: _____ SS#: _____ Birthdate: _____

Address *(if different from patient):* _____

Relationship to Patient: _____

Insurance Company Name: _____ Group #: _____

Insured's Employer: _____ Phone #: _____

Employer's Address: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverages and assign directly to **Above Named Dental Entity** 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. 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, if applicable.

_____

Responsible Party Signature

Relationship _____ Date _____

PLEASE TURN OVER ☞

In order to properly diagnose and treat dental problems we require, and it is recommended by the American Dental Association that a full series of x-rays and/or a Panorax x-ray be taken every 3–5 years. This will incur an additional cost that may not be covered by your insurance.

_____ **I agree to this treatment.**

_____ **I hereby waive the need for this treatment and fully understand the risks involved with not having routine dental x-rays.**

HEALTH HISTORY

Physician's Name _____ Phone No. _____

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

HAVE YOU BEEN ADVISED BY YOUR PHYSICIAN THAT YOU NEED TO BE PRE-MEDICATED FOR DENTAL TREATMENT? ❒ YES ❒ NO

AIDS	❒ YES	❒ NO	Fainting or dizziness	❒ YES	❒ NO	Radiation Treatment	❒ YES	❒ NO
Anemia	❒ YES	❒ NO	Glaucoma	❒ YES	❒ NO	Respiratory Disease	❒ YES	❒ NO
Arthritis, Rheumatism	❒ YES	❒ NO	Headaches	❒ YES	❒ NO	Rheumatic Fever	❒ YES	❒ NO
Artificial Heart Valves	❒ YES	❒ NO	Heart Murmur	❒ YES	❒ NO	Scarlet Fever	❒ YES	❒ NO
Asthma	❒ YES	❒ NO	Heart Problems	❒ YES	❒ NO	Shortness of Breath	❒ YES	❒ NO
Bleeding abnormally, with extractions or surgery	❒ YES	❒ NO	Hepatitis Type _____	❒ YES	❒ NO	Sinus Trouble	❒ YES	❒ NO
Blood Disease	❒ YES	❒ NO	Herpes	❒ YES	❒ NO	Stents	❒ YES	❒ NO
Cancer	❒ YES	❒ NO	High Blood Pressure	❒ YES	❒ NO	Stroke	❒ YES	❒ NO
Chemical Dependency	❒ YES	❒ NO	HIV Positive	❒ YES	❒ NO	Swollen Neck Glands	❒ YES	❒ NO
Chemotherapy	❒ YES	❒ NO	Jaundice	❒ YES	❒ NO	Thyroid Problems	❒ YES	❒ NO
Circulatory Problems	❒ YES	❒ NO	Jaw Pain	❒ YES	❒ NO	Tuberculosis	❒ YES	❒ NO
Congenital Heart Lesions	❒ YES	❒ NO	Joint Replacement (Knee, Hip, etc.)	❒ YES	❒ NO	Tumor or growth on head or neck	❒ YES	❒ NO
Cortisone Treatments	❒ YES	❒ NO	Kidney Disease	❒ YES	❒ NO	Ulcer	❒ YES	❒ NO
Cough, persistent or bloody	❒ YES	❒ NO	Liver Disease	❒ YES	❒ NO	Venereal Disease	❒ YES	❒ NO
Depression	❒ YES	❒ NO	Low Blood Pressure	❒ YES	❒ NO			
Diabetes	❒ YES	❒ NO	Mitral Valve Prolapse	❒ YES	❒ NO			
Emphysema	❒ YES	❒ NO	Pacemaker	❒ YES	❒ NO			
Epilepsy	❒ YES	❒ NO	Psychiatric Care	❒ YES	❒ NO			

Women:
Are you pregnant? ❒ YES ❒ NO
Due Date _____
Are you nursing? ❒ YES ❒ NO

MEDICATIONS

Have you ever taken any of the following medications?

FOSAMAX _____ BONIVA _____ ACTONEL _____

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❒ Aspirin
❒ Barbiturates (Sleeping Pills)
❒ Codeine
❒ Iodine
❒ Local Anesthetic
❒ Penicillin
❒ Sulfa
❒ Latex
❒ Other _____

_____

_____

Doctor's Signature: _____ Date: _____

Date	Update	Signature