Friedman Dental Care
Sidney H. Friedman D.D.S.

Today's Date ______________________________

Patient Name ____ Name you wish to be called ____________________

Home Address ____ Home Phone (_____)______________________

City ___________________________ State ______ Zip Code ______________ Work Phone (_____)______________________

E-Mail (will not be shared) ____ Cell Phone (_____)______________________

Best Time and Place to Reach You ____

Sex: M__ F__ Single __ Married __ **Birthdate** ______________________ Your Social Security # __________________________

Employer ____ Occupation______________________________

Employer Address ____ Employer Phone (_____)______________________

Spouse Name ___________________________ Birthdate ___________________ SS# ___________________________

Spouse's Employer ____ Occupation ______________________________

IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)

Name ____ Relationship to you ___________________________

Address and Phone Number of Emergency Contact Person ____

Who is responsible for this account? _________________________________ Relationship to patient ______________________

Whom may we thank for referring you? ____

INSURANCE

Dental Insurance Carrier____ Group # __________________

Is patient covered by additional insurance ? yes __ no __ Subscriber's name ______________________________________

Subscriber's Birthdate __________________ Subscriber's SS# _______________________ Relationship to Patient __________________

Dental Insurance Carrier____Group # __________________

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________________ and assign directly to doctor 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.

____

Responsible Party Signature Relationship Date

DENTAL HISTORY

Reason for today's visit ____
Date of last dental visit _______________________________ Date of last dental X-rays ___________________________________
How often do you floss?________________ How often do you brush?____________________
Please check if you have any of the following:

O Bad breath	O Swollen/Bleeding gums	O Blisters on lips or mouth
O Clicking or popping jaw	O Smoking	O Fingernail biting
O Jaw joint pain	O Dry mouth	O Chewing tobacco
O Loose teeth	O Food collection between teeth	O Grinding or clenching your teeth
O Broken fillings	O Floss shredding or breaks	O Sores or growths in your mouth
O Pain around ear	O Mouth breathing	O Lip or cheek biting
O Sensitivity to heat/cold	O Sensitivity to biting	O Braces/Orthodontic treatment

Are you happy with the appearance of your teeth? YES NO
If no, what don't you like about your smile? ____
Would you like to discuss how to make your teeth WHITER? YES NO

(OVER)

MEDICAL HISTORY

Physician's Name ____ Date of last visit ________________________

Please check yes or no to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No	
O	O	AIDS	O	O	Glaucoma	O	O	Psychiatric care
O	O	Anemia	O	O	Headaches	O	O	Radiation treatment
O	O	Arthritis, Rheumatism	O	O	Heart Murmur	O	O	Respiratory disease
O	O	Artificial heart valves	O	O	Heart Problems	O	O	Rheumatic fever
O	O	Artificial joints	O	O	Hepatitis (type________)	O	O	Scarlet fever
O	O	Asthma	O	O	Herpes	O	O	Shortness of breath
O	O	Back problems	O	O	High blood pressure	O	O	Sinus trouble
O	O	Diabetes	O	O	HIV positive	O	O	Skin Rash
O	O	Family history of diabetes	O	O	Jaundice	O	O	Special diet
O	O	Excessive bleeding with surgery	O	O	Jaw Pain	O	O	Stroke
O	O	Blood disease	O	O	Joint replacement	O	O	Swelling of feet or ankles
O	O	Cancer	O	O	Kidney disease	O	O	Swollen neck glands
O	O	Chemical dependency	O	O	Low blood pressure	O	O	Smoking
O	O	Chemotherapy	O	O	Mitral valve prolapse	O	O	Thyroid problems
O	O	Circulatory problems	O	O	Nervous problems	O	O	Tonsillitis
O	O	Congenital heart lesions	O	O	Pacemaker	O	O	Tuberculosis
O	O	Cortisone treatments			Women:	O	O	Tumor or growth of head or neck
O	O	Cough, persistent or bloody	O	O	Are you pregnant?	O	O	Ulcer
O	O	Epilepsy	O	O	Taking birth control pills?	O	O	Venereal disease
O	O	Fainting or dizziness	O	O	Are you Nursing?	O	O	Unexplained weight loss

MEDICATIONS:

Please list medications you are currently taking: ____

____

ALLERGIES:

O Aspirin O Local Anesthetic O Codeine O Sulfa O Other ____________________

O Barbiturates (sleeping pills) O Penicillin O Iodine O Latex O No Known Allergies

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company. I understand that I may incur an 8% finance charge if my balance goes beyond 90 days. I give permission for my dentist and clinical team to take any necessary x-rays, study models and photographs to make a complete diagnosis of my dental needs. I understand that these records may be used for educational purposes.

____ ________________________

Patient's Signature Date

(I have read, agree to, and understand the statements listed above)

= =For Future Use =

1. ____date/initial ____________________

2. ____date/initial ____________________

3. ____date/initial ____________________

4. ____date/initial ____________________

5. ____date/initial ____________________

6. ____date/initial ____________________

7. ____date/initial ____________________

8. ____date/initial ____________________

9. ____date/initial ____________________

10. ____date/initial ____________________