Our patients are also our friends. We'd like to get some information about you so that we can get to know you better.

Patient Information

Date_____ Age_____ Sex ☐M ☐F

Patient's Name _____
Last First Middle

Address _____
Street City Sate Zip

Home Phone_____ Birthdate _____ Social Security #_____

Cell Phone _____ Parent's Cell Phone if patient is minor _____ ☐ mother ☐ father

If patient is a minor, give parent's or guardian's name _____

How did you hear about our office? _____

Your E-Mail _____

Who is your general dentist? _____ Last Visit (approx.)_____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Social Security # _____ Birthdate _____ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Insurance Information

Insured's Name _____

Date of Birth_____

Social Security No. _____

Insurance Co. _____

Group No. _____ Local No. _____

Ins. Co. Address _____

_____

Ins. Phone No. _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO YOSSI BAR-ZION, DDS, MS, INC OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____ _____
signed insured person date

Do you have dual coverage? Yes ☐ No ☐

If Yes:

Insured's Name _____

Date of Birth _____

Social Security No. _____

Insurance Co. _____

Group No. _____ Local No. _____

Ins. Co. Address _____

_____

Ins. Phone No. _____

Emergency Information

Name of nearest relative not living with you _____ Relationship_____

Phone _____

Is the patient in good health? Yes ☐ No ☐

Is the patient under the care of a physician? Yes ☐ No ☐

If so please explain

_____

Is the patient presently taking any medications? Yes ☐ No ☐

If so please explain

_____

Does the patient have any history of: (please check yes or no)

Y	N		Y	N		Y	N		Y	N	
☐	☐	Frequent Colds	☐	☐	Allergies	☐	☐	Dizziness or fainting	☐	☐	AIDS/HIV
☐	☐	Heart trouble	☐	☐	Diabetes	☐	☐	Kidney or liver disease	☐	☐	Blood disorders
☐	☐	Rheumatic fever	☐	☐	Hepatitis	☐	☐	Brain injury	☐	☐	Hearing difficulties
☐	☐	Heart murmur	☐	☐	Arthritis	☐	☐	Osteoporosis			

☐ or any other disorder. If so, please outline: _____

_____

Have tonsils and adenoids been removed? Yes ☐ No ☐ if so, date _____

Has patient ever been on Phen-Fen or Redux ? Yes ☐ No ☐ if so, date _____

Has patient ever been on Bisphosphonates (Boniva, Fosamax, Etc) ? Yes ☐ No ☐ if so, date _____

Please check yes or no if patient ever had any of the following habits:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Thumb sucking	☐	☐	Nail biting	☐	☐	Grinding of teeth	☐	☐	Tongue biting
☐	☐	Mouth breathing	☐	☐	Lip biting	☐	☐	Speech disorders	☐	☐	Tongue thrusting

How does the patient feel about getting braces/orthodontic treatment? _____

_____

Did the mother or father of patient have any teeth removed because of crowding? _____

Does anyone in the family have a similar dental condition? _____ Relationship _____

Any clicking or pain when opening or closing the jaw? _____

Has the patient experienced any unfavorable reaction to medical or dental care? _____

Last date of dental care appointment: _____

Please list name, date of birth, and age of any other children in family:

_____

_____

_____

_____

Are there any other family members being seen by Dr. Bar-Zion at this time? Please list names:

_____

_____

_____

Is there anything else that you feel Dr. Bar-Zion should know regarding this patient?

_____

_____

It is your obligation to inform us of any health changes.

Signature (of parent, if minor) _____

For office use only	Date:	Initials: