**PATIENT INFORMATION**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: \_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you?



**PRIMARY INSURANCE |** Carrier: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber employed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID or SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to AMAYA DENTAL/Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT DENTAL AND MEDICAL HISTORY *(Confidential)***

Check if you have or had any of the following dental issues: **Yes [Y] No [N]**

| Bad Breath | Y | N | Periodontal treatment | Y | N |
| --- | --- | --- | --- | --- | --- |
| Bleeding gums | Y | N | Sensitivity to hot or cold | Y | N |
| Blisters on lips or mouth | Y | N | Sensitivity to sweets | Y | N |
| Food collection between teeth | Y | N | Sensitivity when biting | Y | N |
| Grinding teeth | Y | N | Sores or growths in your mouth | Y | N |
| Loose teeth or broken fillings | Y | N | Clicking or popping jaw | Y | N |
| Dry Mouth | Y | N | Gums swollen or tender | Y | N |

How often do you floss? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** How often do you brush? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever taken any of the group of drugs referred to as “fen-phen?”** *These include combinations of Ionominin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).*  **Y**  *or* **N**

Have you had any serious illnesses or operations? If yes, describe: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you ever had a blood transfusion? If yes, give approximate dates: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Check if you have had any of the following medical issues: **Yes [Y] No [N]**

| AIDS/HIV | Y | N | Chemotherapy | Y | N | Heart Problems | Y | N | Rheumatic Fever | Y | N |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Anemia | Y | N | Cortisone Problems | Y | N | Hemophilia | Y | N | Scarlet Fever | Y | N |
| Arthritis, Rheumatism | Y | N | Cough, Persistent | Y | N | Herpes | Y | N | Shortness of Breath | Y | N |
| Artificial Heart Valves | Y | N | Coughing up blood | Y | N | Hepatitis: [A] [B] [C] | Y | N | Skin Rash | Y | N |
| Artificial Joints | Y | N | Diabetes | Y | N | Jaw Pain  | Y | N | Stroke | Y | N |
| Asthma | Y | N | Dizziness/Fainting | Y | N | Kidney Disease | Y | N | Swelling of Feet or Ankles | Y | N |
| Back Problems | Y | N | Epilepsy, head injury | Y | N | Liver Disease | Y | N | Thyroid Problems | Y | N |
| Blood Disease | Y | N | Emphysema | Y | N | Mitral Valve Prolapse | Y | N | Tobacco Habit | Y | N |
| Blood Pressure [H] [L] | Y | N | Glaucoma | Y | N | Mental Disorder | Y | N | Tonsillitis | Y | N |
| Cancer | Y | N | Headaches  | Y | N | Pacemaker | Y | N | Tuberculosis | Y | N |
| Chemical Dependency | Y | N | Hay fever | Y | N | Radiation Treatment | Y | N | Ulcer | Y | N |
| Circulatory Problems | Y | N | Heart Murmur | Y | N | Respiratory Disease | Y | N | Venereal Disease | Y | N |

**MEDICATIONS** - Please provide us with an updated list of all medications you are currently taking.

**PHARMACY INFO - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES |** Check if you are allergic to any of the following:

| Aspirin | **Y** | **N** | Codeine | **Y** | **N** | Penicillin | **Y** | **N** | Latex | **Y** | **N** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Barbiturates  | **Y** | **N** | Local Anesthetic | **Y** | **N** | Sulfa | **Y** | **N** | **Other:** | **Y** | **N** |



*The above information (Front & Back) is accurate and complete to the best of my knowledge. I will not hold my dentist or any*

*member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.*

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_**

*Information (Front & Back) Reviewed by provider.*

**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**