

# A. JAY CITRIN, D.D.S. PATIENT INFORMATION

*(This will be kept confidential. Please print.)*

Patient Name \_\_\_\_\_ Male   
 \_\_\_\_\_ Female  Birthdate \_\_\_\_\_  
 (Last) (First) (Middle)

Single  Married (Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ )  Widow  Divorced  Separated

Residence Address \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

Phone ( \_\_\_\_\_ ) Cell Phone ( \_\_\_\_\_ ) E-mail \_\_\_\_\_

Driver's License No. \_\_\_\_\_ Social Security No. \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_ City, \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_ A/C \_\_\_\_\_ Ext. \_\_\_\_\_

Spouse Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
 Spouse's Business Address \_\_\_\_\_ City, \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_ A/C \_\_\_\_\_ Ext. \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Soc.Sec.No. \_\_\_\_\_  
 (If different from above)

Residence Address \_\_\_\_\_ City, \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_ A/C \_\_\_\_\_ Ext. \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT**

Name of Nearest Relative \_\_\_\_\_ Relationship \_\_\_\_\_  
 (Other than Spouse)

Address \_\_\_\_\_ City, \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_ A/C \_\_\_\_\_ Ext. \_\_\_\_\_

WHO REFERRED YOU TO US? (We wish to thank them) \_\_\_\_\_  
 (Name) (Address)

**DENTAL INSURANCE INFORMATION**

This information is necessary to make sure you receive the maximum benefits that you are entitled to. Thank you.

Employee's Name \_\_\_\_\_ SSN or ID# \_\_\_\_\_  
 \_\_\_\_\_ Group or Union No. \_\_\_\_\_

Name of Insurance Co. or Union \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

If patient is covered by more than one dental insurance, please complete the following:

Name of Spouse \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Relationship \_\_\_\_\_  
 \_\_\_\_\_ Group or Union No. \_\_\_\_\_

Name of Insurance Co. or Union \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS TO DENTIST**

I hereby authorize payment directly to the above dentist for the surgical and/or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**TERMS & CONDITIONS**

As a condition of your treatment by this office, financial arrangements must be made in advance.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A finance charge of 1½% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within (5) days of billing if credit shall be extended.

I grant my permission to you, or to your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed: \_\_\_\_\_ Date \_\_\_\_\_

# HEALTH HISTORY

PATIENT'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

## MEDICAL

- |   | <b>Circle</b> | <b>Yes</b> | <b>or</b> | <b>No</b> |
|---|---------------|------------|-----------|-----------|
| 1. Are you in good health .....   |               | <b>Yes</b> |           | <b>No</b> |
| 2. Has there been any change in your general health within the past year? .....   |               | <b>Yes</b> |           | <b>No</b> |
| 3. Date of last physical examination .....  |               | <b>Yes</b> |           | <b>No</b> |
| 4. Are you now under the care of a physician? .....   |               | <b>Yes</b> |           | <b>No</b> |
| If so, explain .....  |               |            |           |           |
| 5. Have you ever had any serious illness, operation, or hospitalization? .....  |               | <b>Yes</b> |           | <b>No</b> |
| If so, explain .....  |               |            |           |           |
| 6. Are you taking any drugs or medicine? .....  |               | <b>Yes</b> |           | <b>No</b> |
| If so, explain .....  |               |            |           |           |
| 7. Are you sensitive or allergic to any drugs? <input type="checkbox"/> Penicillin or other antibiotic; <input type="checkbox"/> Sulfa; .....   |               | <b>Yes</b> |           | <b>No</b> |
| <input type="checkbox"/> Codeine or other narcotic; <input type="checkbox"/> Aspirin; <input type="checkbox"/> Barbiturates; <input type="checkbox"/> Iodine <input type="checkbox"/> Other .....   |               |            |           |           |
| 8. Do you have, or have you had any of the following: (Please check <input checked="" type="checkbox"/> known conditions) .....   |               | <b>Yes</b> |           | <b>No</b> |
| <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Diseases <input type="checkbox"/> Rheumatism or Arthritis <input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Heart Ailments <input type="checkbox"/> Hepatitis, Jaundice or liver Disease <input type="checkbox"/> Head Injuries<br><input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Stomach Ulcers<br><input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Tumors or Growths <input type="checkbox"/> Venereal Disease<br><input type="checkbox"/> Tuberculosis <input type="checkbox"/> Radiation Treatment of any kind <input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Aids/HIV <input type="checkbox"/> Allergies <input type="checkbox"/> Mental/Nervous Disorders<br><input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma or Hay Fever <input type="checkbox"/> Stroke<br><input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Fainting Spells or Seizures <input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Other |               |            |           |           |
| 9. <b>Do you have AIDS or the HIV VIRUS?</b> .....  |               | <b>Yes</b> |           | <b>No</b> |
| 10. <b>Do you have Osteoporosis? What Medications are you taking?</b> .....   |               | <b>Yes</b> |           | <b>No</b> |
| 11. <b>Have you had any excessive bleeding requiring special treatment?</b> .....   |               | <b>Yes</b> |           | <b>No</b> |
| 12. <b>Have you had a heart valve or joint (knee, hip, shoulder, etc.) replacement?</b> .....   |               | <b>Yes</b> |           | <b>No</b> |
| 13. <b>Any other need to pre-medicate?</b> .....  |               | <b>Yes</b> |           | <b>No</b> |
| 14. Do you have any disease or condition or problem not listed above that you think I should know about? .....  |               | <b>Yes</b> |           | <b>No</b> |
| 15. (Women) Are you pregnant or nursing? If so, how many months? .....  |               | <b>Yes</b> |           | <b>No</b> |

## DENTAL

- |  |  |            |  |           |
|--|--|------------|--|-----------|
| 1. Previous Dentist _____ City _____   |  |            |  |           |
| 2. Have you been having any specific problem? .....  |  | <b>Yes</b> |  | <b>No</b> |
| Explain: .....   |  |            |  |           |
| 3. Does dental treatment make you nervous? .....   |  | <b>Yes</b> |  | <b>No</b> |
| If so, <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Severely   |  |            |  |           |
| 4. Do you have, or have you had any of the following: (Please check <input checked="" type="checkbox"/> known conditions) .....  |  | <b>Yes</b> |  | <b>No</b> |
| <input type="checkbox"/> Bad Breath <input type="checkbox"/> Loosening of Teeth <input type="checkbox"/> Headaches <input type="checkbox"/> Bleeding Gums<br><input type="checkbox"/> Sensitive Teeth <input type="checkbox"/> Jaws "Pop" or "Lock" <input type="checkbox"/> Sinus Trouble |  |            |  |           |
| 5. Have you ever had any of the following? .....   |  | <b>Yes</b> |  | <b>No</b> |
| <input type="checkbox"/> Injury <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Orthodontics <input type="checkbox"/> Periodontics  |  |            |  |           |
| Explain: .....   |  |            |  |           |
| 6. Have you ever had any unfavorable reaction from a local anesthetic? .....   |  | <b>Yes</b> |  | <b>No</b> |
| 7. Have you had any serious trouble associated with any previous dental treatment? .....   |  | <b>Yes</b> |  | <b>No</b> |
| 8. How long since your last dental x-rays? .....   |  |            |  |           |
| 9. How long since your last dental treatment? .....  |  |            |  |           |
| 10. Would you desire to be pre-sedated? <input type="checkbox"/> Nitrous Oxide <input type="checkbox"/> Drugs <input type="checkbox"/> Or .....  |  | <b>Yes</b> |  | <b>No</b> |
| 11. It is our intention to make your visit as comfortable as possible. Please comment on how we may further this for you.  |  |            |  |           |

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_

If minor, relationship to patient \_\_\_\_\_

**Changes in Health** \_\_\_\_\_

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_

**Changes In Health** \_\_\_\_\_

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_

Reviewed Summary _____
Date _____ Dr. _____
Date _____ Dr. _____
Date _____ Dr. _____
<b>DO NOT WRITE IN THIS SPACE</b>

**CONSENT FOR TREATMENT:** I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this Health History form to administer any treatment; or to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

"ALL SERVICES ARE RENDERED AND ACCEPTED UNDER THE TERMS AND CONDITIONS PRINTED ON THE REVERSE HEREOF"

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

Authorization must be signed by the patient, or by the nearest relative in case of a minor or when the patient is physically or mentally incompetent.

**Relationship** \_\_\_\_\_