Welcome to the Office of - **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# _____

Name of Insurance Co. or Union _____ Group or Union No. _____

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 _____

Name of Insurance Co. or Union _____ Group or Union No. _____

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** _____

PLEASE COMPLETE BOTH SIDES!

Health History

PATIENT'S NAME _____ BIRTHDATE _____

PHYSICIAN'S NAME _____ PHONE (_____) _____

ADDRESS _____ CITY _____ ZIP _____

MEDICAL **Circle Yes or No**

1. Are you in good health ..... **Yes No**
2. Has there been any change in your general health within the past year? ..... **Yes No**
3. Date of last physical examination ..... **Yes No**
4. Are you now under the care of a physician? ..... **Yes No**
   If so, explain.....
5. Have you ever had any serious illness, operation, or hospitalization? ..... **Yes No**
   If so, explain _____
6. Are you taking any drugs or medicine? ..... **Yes No**
   If so, explain _____
7. Are you sensitive or allergic to any drugs? ❑ Penicillin or other antibiotic; ❑ Sulfa; ..... **Yes No**
   ❑ Codeine or other narcotic; ❑ Aspirin; ❑ Barbiturates; ❑ Iodine ❑ Other _____
8. Do you have, or have you had any of the following: (Please check ✓ known conditions) ..... **Yes No**

❑ Anemia	❑ Blood Diseases	❑ Rheumatism or Arthritis	❑ Osteoporosis
❑ Heart Ailments	❑ Hepatitis, Jaundice or liver Disease	❑ Head Injuries	
❑ High Blood Pressure	❑ Kidney Disease	❑ Stomach Ulcers	
❑ Respiratory Disease	❑ Tumors or Growths	❑ Venereal Disease	
❑ Tuberculosis	❑ Radiation Treatment of any kind	❑ Epilepsy	
❑ Aids/HIV	❑ Allergies	❑ Mental/Nervous Disorders	
❑ Diabetes	❑ Asthma or Hay Fever	❑ Stroke	
❑ Excessive Bleeding	❑ Fainting Spells or Seizures	❑ Glaucoma	
❑ Rheumatic Fever	❑ Sinus Trouble	❑ Other	

9. **Do you have AIDS or the HIV VIRUS?** ..... **Yes No**
10. **Do you have Osteoporosis? What Medications are you taking?** ..... **Yes No**
11. **Have you had any excessive bleeding requiring special treatment?** ..... **Yes No**
12. **Have you had a heart valve or joint (knee, hip, shoulder, etc.) replacement?** ..... **Yes No**
13. **Any other need to pre-medicate?** ..... **Yes No**
14. Do you have any disease or condition or problem not listed above that you think I should know about? ..... **Yes No**
15. (Women) Are you pregnant or nursing? If so, how many months? ..... **Yes No**

DENTAL

1. Previous Dentist _____ City _____
2. Have you been having any specific problem? ..... **Yes No**
   Explain: _____
3. Does dental treatment make you nervous? ..... **Yes No**
   If so, ❑ Slightly ❑ Moderately ❑ Severely
4. Do you have, or have you had any of the following: (Please check ✓ known conditions) ..... **Yes No**
   ❑ Bad Breath ❑ Loosening of Teeth ❑ Headaches ❑ Bleeding Gums
   ❑ Sensitive Teeth ❑ Jaws "Pop" or "Lock" ❑ Sinus Trouble
5. Have you ever had any of the following? ..... **Yes No**
   ❑ Injury ❑ Oral Surgery ❑ Orthodontics ❑ Periodontics
   Explain: _____
6. Have you ever had any unfavorable reaction from a local anesthetic? ..... **Yes No**
7. Have you had any serious trouble associated with any previous dental treatment? ..... **Yes No**
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? ❑ Nitrous Oxide ❑ Drugs ❑ Or _____ **Yes No**
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. _____

DO NOT WRITE IN THIS SPACE

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of the care of the patient whose name appeals 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 _____