Maduri Family Dental

Financial Information

In order to better serve your needs, please complete the following information completely. We will be happy to assist you with any questions. We look forward to serving all your dental health needs. Please complete both sides. Thank you!

Date _____ Patient Primary Phone Number _____

Patient Information

Name _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Emergency Contact Name _____ Phone _____

Birth Date _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

E-mail address _____ Who may we thank for referring you? _____

Spouse's/Parent's Name _____ Primary Phone Number _____

Nearest Relative not living with you _____ Phone _____

If patient is a student, name of school/college _____ □ Full time □ Part time

Responsible Party (If patient is a child, this will be the parent/guardian bringing the child to appointment)

Name of person responsible for this account _____

Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Cell Phone _____

Relationship to patient _____ Soc. Sec. # _____

Employer _____ Employer Phone Number _____

Employer Address _____ City _____ State _____ Zip _____

Insurance

Primary Insurance

Employee Name _____ Relationship to Patient_____ Date of Birth _____

Employer _____ Employer Phone Number _____

Name of Dental Insurance Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

Group Number _____ Subscriber ID# _____ Subscriber Soc. Sec. # _____

Secondary Insurance

Employee Name _____ Relationship to Patient_____ Date of Birth _____

Employer _____ Employer Phone Number _____

Name of Dental Insurance Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

Group Number _____ Subscriber ID# _____ Subscriber Soc. Sec. # _____

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Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Former Dentist Phone Number _____ Last visit at their office _____

Date of last x-rays _____

Check (X) if you have had problems with any of the following:

□ Bad Breath
□ Bleeding gums
□ Clicking or popping jaw
□ Food collection between teeth
□ Grinding or clenching teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Sensitivity to cold
□ Sensitivity to hot
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sore or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____ Your smile? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?_____

Other information about your dental health or previous treatment _____

Medical History

Physician's Name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? _____

If yes, explain _____

Are you currently under physician care? _____ If year, explain _____

Have you ever had a blood transfusion? _____ If yes, give approximate dates _____

Women: Are you pregnant? _____ Nursing? _____ Taking birth control pills? _____

Do you or have you ever used prescription drugs or other forms of drugs recreationally? _____

Check (X) if you have had any of the following:

□ AIDS/HIV positive
□ Anaphylaxis
□ Anemia
□ Arthritis, Rheumatism
□ Artificial heart valves
□ Artificial joints
□ Asthma
□ Atopic (allergy prone)
□ Back problems
□ Blood disease
□ Cancer
□ Chemical dependency
□ Chemotherapy
□ Circulatory problems
□ Cortisone treatments
□ Cough, persistent
□ Cough up blood
□ Diabetes
□ Epilepsy
□ Fainting
□ Food allergies
□ Glaucoma
□ Headaches
□ Heart murmur
□ Heart problems
Describe_____
□ Hemophilia/abnormal bleeding
□ Herpes
□ High blood pressure
□ Jaw pain
□ Kidney disease or malfunction
□ Liver disease
□ Material allergies (latex, metal)
□ Mitral valve prolapse
□ Nervous problems/Pacemaker
□ Heart surgery
□ Psychiatric care
□ Rapid weight gain or loss
□ Radiation treatment
□ Rheumatic/Scarlet fever
□ Shingles
□ Shortness of breath
□ Skin rash
□ Spina Bifida
□ Stroke
□ Surgical implant
□ Swelling of feet or ankles
□ Thyroid disease or malfunction
□ Tobacco habit
□ Tonsillitis
□ Tuberculosis
□ Ulcer/colitis
□ Venereal disease

Is patient currently taking any medication? If yes, list all _____

_____

Does patient have any drug allergies? If yes, list all _____

Is patient allergic or have sensitivity to any of the following (please circle): Banana, Kiwi, Avocado, Papaya, Melon, Peach, Chestnut,

Hazelnut, Other _____

Authorization

I have reviewed the information on this financial and health form, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions and complaints. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand I am responsible for payment at time of service. I understand I will incur a $7.00 monthly billing charge for all unpaid balances on my account.

Signature _____ Date _____