DOCTOR Kaz
Family & Cosmetic Dentistry
(302) 235-SMILE • www.drkaz.org

Name:_____
Last First MI Title

Preferred Name: _____ ❑ Male ❑ Female

Address: _____ City _____ State _____ ZIP_____

SSN:_____ DOB:_____

HomePhone:_____ WorkPhone:_____

CellPhone:_____ E-mailAddress:_____

Employer:_____ Occupation: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

How did you hear about our office?_____

Do you prefer to be contacted for appointment confirmation via e-mail or phone? _____(Please circle preference)

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address:_____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address:_____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Kaz Family & Cosmetic Dental 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature:_____

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Medical History

Do you have a personal physician?
Physician's Name:_____
Physician's Phone:
Date of last visit: _____
Your current physical health is: ❑ Good ❑ Fair ❑ Poor
Are you currently under the care of a physician? ❑ Yes ❑ No
Please explain: _____
Do you use tobacco in any form? ❑ Yes ❑ No
Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No
Are you taking any medications? ❑ Yes ❑ No
Please list each one: _____
Have you ever had any surgical procedures? ❑ Yes ❑ No
Please list each one: _____

Yes	No	Conditions
❑	❑	Abnormal Bleeding
❑	❑	Alcohol Abuse
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Asthma
❑	❑	Blood Transfusion
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Colitis
❑	❑	Congenital Heart Defect
❑	❑	Diabetes
❑	❑	Difficulty Breathing
❑	❑	Drug Abuse
❑	❑	Emphysema
❑	❑	Epilepsy
❑	❑	Facial Surgery
❑	❑	Fainting Spells
❑	❑	Fever Blisters
❑	❑	Frequent Headaches

Yes	No	Conditions
❑	❑	Glaucoma
❑	❑	HIV+ AIDS
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Heart Surgery
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	High Blood Pressure
❑	❑	Joint Replacement
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Low Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Pace Maker
❑	❑	Psychiatric Problems
❑	❑	Radiation Therapy
❑	❑	Rheumatic Fever
❑	❑	Seizures
❑	❑	Sexually Transmitted Disease
❑	❑	Shingles

Yes	No	Conditions
❑	❑	Sickle Cell Disease
❑	❑	Sinus Problems
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Tuberculosis

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Jewelry
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin
❑	❑	Tetracycline

Yes	No	If Female, Please Answer
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If so, #of Weeks _____
❑	❑	Are you nursing

Nearest relative not living with you:
Name:_____ Relationship: _____
Address:_____ Phone:_____
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
Signature:_____ Date:_____

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Dental History

How may we help you today? _____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Are you under stress? (new job, moving, relationships) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times do you floss/week? _____ brush/day? _____

Are your teeth sensitive to head, cold or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? _____

Are your teeth sensitive to head, cold or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit?_____

_____

Here a Dr. Kaz Family & Cosmetic Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Implant Crowns	Sealants
Partials/Dentures	Veneers	Smile Makeover
Crown and Bridge	Night/Sport Guards	Invisalign