Emanuel Gottlieb
D.D.S.

Welcome! We are pleased that you have chosen us to care for your dental health. Please help us by taking a minute to fill out both sides of this form. We promise that all of this information will remain confidential.

PATIENT INFORMATION FORM

PATIENT'S NAME _____ DATE OF BIRTH _____

HOME ( )_____ CELL ( )_____ WORK ( )_____ EMAIL _____

SPOUSE'S NAME _____ PATIENT DRIVER'S LIC NUMBER _____

HOME ADDRESS _____ PATIENT SOCIAL SECURITY NO _____

CITY _____ STATE _____ ZIP _____

Have you seen our new website www.gotdentist.com? ❑ Yes ❑ No

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN _____ POLICY # _____ GROUP # _____

NAME OF INSURANCE COMPANY _____ PHONE ( )_____

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT _____

_____

EMPLOYED BY _____ POSITION _____ WORK ( )_____
(Name of Company)

BUSINESS ADDRESS _____ CITY/STATE _____ ZIP _____

IF MARRIED, OCCUPATION OF YOUR HUSBAND (OR WIFE) _____

FOR WHAT COMPANY DOES HE (SHE) WORK? _____ PHONE ( )_____ EXT_____

IN CASE OF EMERGENCY (*NEAREST RELATIVE*)

_____ ( )_____
(NAME) (ADDRESS) (CITY)

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

MEDICAL HISTORY

PRIMARY PHYSICIAN'S NAME _____ PHONE ( ) _____

ADDRESS _____ DATE OF LAST PHYSICAL EXAM _____

HAVE YOU BEEN UNDER A MEDICAL DOCTOR'S CARE OR HOSPITALIZED WITHIN THE PAST FIVE YEARS? _____

Have you ever had or do you have:

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Problems	❑	❑	Excessive Bleeding	❑	❑	Psychiatric Care	❑	❑	Anemia	❑	❑	Venereal Disease	❑	❑
Heart Murmur	❑	❑	Rheumatic Fever	❑	❑	Tuberculosis	❑	❑	Aids	❑	❑	Hepatitis	❑	❑
Artificial Joint	❑	❑	Epilepsy or Seizures	❑	❑	Sinus Problems	❑	❑	Stroke	❑	❑	Yellow Jaundice	❑	❑
Diabetes	❑	❑	Abnormal Blood Pressure	❑	❑	Malignancies	❑	❑	Asthma	❑	❑	Substance Abuse	❑	❑

Other _____

Are you allergic to: Penicillin ❑ Codeine ❑ Novocain ❑ Other ❑ (please specify) _____

Do you smoke? ❑Yes ❑No Are you pregnant? ❑Yes ❑No Are you nursing? ❑Yes ❑No Blood Pressure: S_____ D _____

Are you presently taking any medications? ❑Yes ❑ No If yes, please list them _____

RMH ❑ Date _____ Comments _____

DENTAL HISTORY

What concerns you most regarding our dental needs? _____

Are you having any discomfort at this time? _____ What is the discomfort? _____

How long has it been since you've seen a dentist? _____ What was done at that time? _____

Did you have X-Rays? ❑Yes ❑No How often did you visit a dentist before then? _____ Have you lost any teeth? _____

Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

Have you ever had braces? ❑Yes ❑No Do you ever hear clicking or popping noises in your jaw? ❑Yes ❑No

Do you have trouble opening or closing your mouth? ❑Yes ❑No Does food get trapped in your teeth? ❑Yes ❑No

Are your teeth sensitive to heat, cold, sweets or biting pressure? ❑Yes ❑No

Are there old fillings or dental work that you don't like looking at? ❑Yes ❑No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail. The undersigned understand that they shall be responsible for the payment of charges incurred for all services rendered, and gives permission for necessary and approved services rendered.

Date _____ Your Signature _____

(Signature of Parent or Guardian)