Welcome to Marze Dental!

DATE_____ **SOCIAL SECURITY #**_____ Male____ Female_____

PATIENT_____ DATE OF BIRTH_____

TELEPHONE_____ CELL/PAGER # _____

PHYSICAL STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

MAILING ADDRESS if different _____

E-MAIL ADDRESS_____ DRIVER'S LICENSE_____

EMPLOYER_____ WORK TELEPHONE_____

Or SCHOOL ATTENDING _____ CITY_____

MARRIED * YES____ NO_____ SPOUSE'S NAME_____

RESPONSIBLE PARTY FOR PATIENTS UNDER 18.
(If patient is 18 yrs of age or older and responsible party is not self – please clarify reason, fill below and sign back)

NAME _____ SS#_____

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH_____

DRIVER'S LICENSE_____

ADDRESS* STREET_____ TELEPHONE_____

CITY_____ STATE_____ ZIP_____

EMPLOYER_____ BADGE # if applicable_____

ADDRESS_____ WORK TELEPHONE_____

DENTAL INSURANCE*YES_____NO_____ (Information **must be provided** for areas in **BOLD** type)

INSURANCE CO NAME_____ GROUP #_____

ADDRESS _____ STATE_____ ZIP _____ PHONE #_____

EMPLOYER NAME _____**EMPLOYEE NAME** _____

EMPLOYEE BIRTHDATE_____ ID#_____

FRONT & BACK PLEASE

Patient's name:_____ **MEDICAL HISTORY**

Referred by_____
Purpose of today's visit_____Last dental visit_____
Patient's Physician_____Date of last exam_____
Physician's office telephone # _____
Are you under a Physician's care?_____Please Explain_____
_____
Does your medical doctor require you to have antibiotics prior to dental treatment?_____
Do you have any medical problems?_____
Have you ever had excessive bleeding requiring special treatment?_____
Do you regularly take medication or drugs of any kind?_____**Please List** _____
_____
_____
Have you had a physical within the last 2 years?_____Date_____
(Woman) Are you pregnant now?_____Due date_____
Remarks and additional information_____
Is today's visit due to an accident/injury? _____ **Explain** _____

Do you have or have had any of the following conditions? Please check yes OR no on all conditions.

	YES	NO		YES	NO
Heart Condition	☐	☐	Hepatitis,TYPE_____	☐	☐
Stents	☐	☐	Liver Disease	☐	☐
Heart Murmur	☐	☐	AIDS/ARC	☐	☐
Valve Disorder/Replacement	☐	☐	Thyroid Disease	☐	☐
Pacemaker	☐	☐	Radiation Treatment	☐	☐
Hip/Joint replacement	☐	☐	Tuberculosis	☐	☐
Rheumatic Fever	☐	☐	Smoker	☐	☐
Osteoporosis	☐	☐	If yes, how many packs a day:_____		
Medication _____			Anemia	☐	☐
High Blood Pressure	☐	☐	Asthma	☐	☐
Stroke	☐	☐	Stomach Ulcer	☐	☐
Epilepsy	☐	☐	History of Temporomandibular		
Diabetes	☐	☐	Joint Dysfunction	☐	☐
Kidney Disease	☐	☐			

DRUG ALLERGIES

Penicillin	☐	☐	Sulfa	☐	☐
Local Anesthetic	☐	☐	Erythromycin	☐	☐
Aspirin	☐	☐	Ibuprofen/Advil	☐	☐
Codeine	☐	☐	Tetracycline	☐	☐
Epinephrine	☐	☐	Other_____		

We do not render our services on the basis that insurance companies will pay our fees. You are responsible for **any** amount that your insurance does not pay. I accept financial responsibility for the above named person.

Signature of Responsible Party and/or Parent of Minor_____

Nearest relative in case of emergency_____Phone_____