WELCOME FORM

1. Patient's Name (Last) ____________________ **(middle initial)** ______ **(First)** ______________________
Address ____**Apartment #**______________
City ____**State** ______ **Zip** ______________________
Driver License _________ **Social Security #** ________________ **Birth Date** ___/___/___ **Age** ___ **Sex**___
Telephone (Home#) ________________ **(Cell#)** _________________ **Marital Status**________________
Email Address_________________________

Which is the best way to contact you? Post card_____ **e-mail** _____ **phone# (cell, home or work)**_________

2. Employer ____ **Telephone #** _____________________
Address __________________________ **City** ________________________ **State** _____ **Zip** _________

3. Responsible Party ____ **Driver** License ______________
Relation to Patient ____ Social Security # ____________

4. In Case of Emergency Call____________________________________Relationship______________
Telephone (Home) ___________________ (Work) _________________ (Cell) ___________________
Address____________________________ City__________________ State ______Zip_______________

5. Whom can we thank for referring you to our office? _______________________________________

6. Insured Patients Only
Insurance Comp. Name_____________________________ Phone #_________________________________
Insured's Name ____________________ ID# ______________ Social Security#________________________
Birth Date __/__/____ Group # _______

Are you covered by a second insurance company? YES/NO
If yes, Insurance Co. ___________________________ Telephone # __________________ SS#______________
Insured's Name ______________________ ID ______________ Birth Date __/__/____ Group # _______________

Our office is happy to cooperate with patients covered by dental insurance. As a courtesy, we will fill out and file all necessary forms; however, you will be asked to pay the deductible and your portion of the charges the day of service. We will gladly estimate your coverage, and we need your patient portion while waiting for payment from your insurance company. Remember, it is just an **ESTIMATE**. If, after 45 days, the insurance company has not paid, the balance will be due in full.
I agree if any default of the above agreement on my part needs legal action, I shall assume all responsibility for interest, and reasonable attorney fees. I have read and understand the above information.
Print Name_______________________________ Signature ___________________ Date____/____/____

Assignment of Benefits
I hereby authorize __________________________________Insurance Company to make payment directly
To **NED PANIAGUA DMD** for the dental benefits otherwise payable to me. The foregoing agreement is made in consideration of professional services beginning on _________________.I hereby represent that I am of legal age and legally competent to make this assignment.
Print Name_______________________________ Signature ___________________ Date____/____/____

Payment is due in full at the time of service, unless specific arrangements are made in advance.
As a convenience we accept cash, check, credit cards and we offer patient financing with care credit

HEALTH HISTORY Name____

I. Check Appropriate Answers: (Leave blank if you do not understand the question)

Yes	No	#	Question
☐	☐	1.	Is your general health good? ______________________
☐	☐	2.	Has there been a change in your health within the last year? ______________________
☐	☐	3.	Have you been hospitalized or had a serious illness in the last three years? ______________________ Please explain______________________
☐	☐	4.	Are you being treated by a Physician now? ______________________ Please explain______________________ Date of last general exam ____/_____/_______Date of last Dental exam____/____/____
		5.	If you answer yes to 4, **name of your Physician**______________________ Phone Number (_____)______________________
☐	☐	6.	Have you had problems with prior dental treatment? Please explain______________________
☐	☐	7.	Are you in pain now? Explain______________________

II. Have You Experienced:

Yes	No	#	Question
☐	☐	8.	Chest pain (angina)?
☐	☐	9.	Swollen ankles
☐	☐	10.	Shortness of breath?
☐	☐	11.	Recent weight loss, fever, night sweat?
☐	☐	12.	Persistent cough, Coughing up blood?
☐	☐	13.	Bleeding problems, bruising easily?
☐	☐	14.	Sinus problems?
☐	☐	15.	Difficulty swallowing?
☐	☐	16.	Diarrhea, constipation, blood in stools?
☐	☐	17.	Frequent vomiting, nausea?
☐	☐	18.	Difficulty urinating, blood in urine?
☐	☐	19.	Dizziness?
☐	☐	20.	Ringing in the ears?
☐	☐	21.	Headaches?
☐	☐	22.	Fainting spells?
☐	☐	23.	Blurred vision?
☐	☐	24.	Seizures?
☐	☐	25.	Excessive thirst?
☐	☐	26.	Frequent urination?
☐	☐	27.	Dry mouth?
☐	☐	28.	Jaundice?
☐	☐	29.	Joint pain, stiffness?

III. Do you Have Or Have You Had:

Yes	No	#	Question
☐	☐	30.	Heart disease? Explain______________________
☐	☐	31.	Heart attack? Explain______________________
☐	☐	32.	Heart murmur?
☐	☐	33.	High Blood pressure?
☐	☐	34.	Stroke, hardening of arteries?
☐	☐	35.	Rheumatic fever?
☐	☐	36.	TB, emphysema, other lung diseases?
☐	☐	37.	Hepatitis, other liver disease?
☐	☐	38.	Stomach problems, ulcers?
☐	☐	39.	**Allergies?** ____________**Latex**? Yes___ No___
☐	☐	40.	Family history of diabetes, heart problems, tumors?
☐	☐	41.	AIDS or ARC?
☐	☐	42.	HIV positive
☐	☐	43.	VD (syphilis or gonorrhea)?
☐	☐	44.	Herpes?
☐	☐	45.	Skin diseases?
☐	☐	46.	Eye disease?
☐	☐	47.	Anemia
☐	☐	48.	Arthritis, rheumatism?
☐	☐	49.	Kidney, bladder disease?
☐	☐	50.	Thyroid, adrenal disease?
☐	☐	51.	Diabetes?

IV. Do You Have Or Have You Had:

Yes	No	#	Question
☐	☐	52.	Tumors, cancer?
☐	☐	53.	Radiation treatments?
☐	☐	54.	Chemotherapy?
☐	☐	55.	Prosthetic heart valve?
☐	☐	56.	Artificial joint?
☐	☐	57.	Contact lenses?
☐	☐	58.	Blood transfusions?
☐	☐	59.	Surgeries?
☐	•	60.	Pacemaker?
☐	☐	61.	Psychiatric care?

V. Are You Taking:

Yes	No	#	Question
☐	☐	62.	Recreational drugs? (Addiction)
☐	☐	63.	Tobacco in any form?
☐	☐	64.	Alcohol?
☐	☐	65.	**Medications**, (including Aspirin)?

Please list: ____
____

VI. Women Only:

Yes	No	#	Question
☐	☐	66.	Are you or could you be pregnant or nursing?
☐	☐	67.	Taking birth control pills?

VII. All Patients:

Yes	No	#	Question
☐	☐	68.	Do you have had any other diseases or medical problems NOT listed on this form? Please explain______________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Ned Paniagua of any change in my health and or medication.

Date____/____/_____Patient's Signature______________________________________Doctor______________________________________

RECALL REVIEW

1. Date____/____/____Medical Changes__________________________ Patient's Signature__________________________Doctor________________
2. Date____/____/____Medical Changes__________________________ Patient's Signature__________________________Doctor________________
3. Date____/____/____Medical Changes__________________________ Patient's Signature__________________________Doctor________________