Evan N. Padousis, D.D.S., P.A.
ROSEDALE FAMILY AND COSMETIC DENTISTRY

PATIENT INFORMATION

Date: _____

Patient's Name: _____ Home Phone: _____ Cell: _____

Address: _____ How Long at This Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Employer's Phone: _____

Employer's Address: _____

Social Security No.: _____ Driver's License No.: _____

Birthdate: _____ Sex: M F

Spouse's Name: _____ No. of Children: _____

Parent or Guardian Responsible for Account (if under 18): _____

Referred by: _____

Physician's Name: _____ Physician's Phone: _____

Student: ❑Full-Time ❑Part-Time ❑N/A School Name & Address: _____

E-Mail: _____ Contact Preference: ❑ Text ❑ E-mail

Nearest Relative Not Residing With You: _____

Relationship to Patient: _____ Phone: _____

DENTAL INSURANCE INFORMATION

Primary Insurance:

Subscriber Name: _____

Birthdate of Subscriber: _____

Employer of Subscriber: _____

Employer's Address: _____

S.S. # of Subscriber: _____

Group #: _____

Insurance Co. Name & Address:

_____

_____

_____

Secondary Insurance:

Subscriber Name: _____

Birthdate of Subscriber: _____

Employer of Subscriber: _____

Employer's Address: _____

S.S. # of Subscriber: _____

Group #: _____

Insurance Co. Name & Address:

_____

_____

_____

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Patient or Responsible Party: _____ Date _____ State Driver's License # _____

Responsible party currently has an account with this office? ❑Yes ❑No ❑I wish to discuss the Dental Office's Financial Policy

❑Payment in full at each appointment (cash or personal check) ❑Payment in full at each appointment (❑VISA ❑MC ❑Other)

Card # _____ Exp. Date _____

SERVICE CHARGE: If I do not pay the entire new balance within ___ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be added to account for the current monthly billing period. The service charge will be a periodic rate of ___% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of ___% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect the collection of the account or future outstanding accounts.

Would you consider your overall health to be: poor fair good excellent - Please circle

Are you under a physician's care now? _____ Dr.'s Name & Phone: _____

If so, please give reason for treatment: _____

_____

Are you taking any kind of medication or drugs (prescribed or recreational) at this time (like aspirin, blood thinners, etc.)

If so, please list: _____

_____

Are you or have you ever been an IV drug user? _____

Do you have any allergies to medications or anesthetics, like penicillin. If so, please state: _____

Date of last medical physical exam? _____

Do you have or have you ever had the following? Please check: **Yes** or **No**

Yes	No		Yes	No		Yes	No	
❑	❑	rheumatic fever	❑	❑	kidney or liver illness	❑	❑	glaucoma
❑	❑	heart trouble	❑	❑	dialysis	❑	❑	sexually transmitted disease
❑	❑	high blood pressure	❑	❑	tuberculosis	❑	❑	AIDS/HIV Positive
❑	❑	heart murmur	❑	❑	lung disease/emphysema	❑	❑	Thyroid Disease
❑	❑	mitral valve prolapse	❑	❑	asthma	❑	❑	Fibromyalgia
❑	❑	diabetes	❑	❑	sinus trouble	❑	❑	drug or alcohol addiction
❑	❑	bleeding/clotting disorder	❑	❑	stomach problems/gastric reflux	❑	❑	eating disorder
❑	❑	anemia	❑	❑	take fosamax/bisphosphonate	❑	❑	joint replacement
❑	❑	congenital heart lesions	❑	❑	cancer	❑	❑	cortisone medication (prednisone)
❑	❑	angina pectoris	❑	❑	organ transplant			
❑	❑	stroke/mini-stroke	❑	❑	latex allergy	❑	❑	do you snore?
❑	❑	hepatitis A, B, C	❑	❑	epilepsy	❑	❑	do you smoke?
❑	❑	penicillin allergy	❑	❑	do you take blood thinners?	❑	❑	depression/anxiety

Any prosthetic devices implanted? Examples: pacemaker, heart valve, joint or hip replacement: _____

Doctor's Comments: _____

Have you ever been hospitalized? _____ When? _____ Reason: _____

Are you taking Birth Control Pills? _____

(Women): Are you pregnant? ____ If yes, how many months? _____ Dr.'s Name & Phone: _____

Have you ever had trouble with prolonged bleeding after surgery or extraction, or do you bruise easily? _____

Do any wounds heal slowly or present complications? _____

Is there any other information that should be known about your health? _____

_____

Have you ever had any tumors or growths treated by x-ray radiation or chemotherapy? _____

When was your lastest dental exam and cleaning? _____

Have you ever had an adverse reaction to anesthetics (novacaine)? _____

Any problems with previous dental visits? _____

Do your gums bleed or do you have a bad taste in your mouth? _____

Do you grind or clench your teeth during the night or day? _____

Have you ever been told that you have periodontal disease (gum disease)? _____

Do you have unhealed injuries, inflamed areas, growths or sore spots in your mouth? _____

How do you evaluate your present dental health? poor fair good -Please circle

Are you pleased with your smile and the color of your teeth? _____

If there is anything that you would like to change about your teeth or smile, what would you change? _____

Signature: _____ Date: _____

Updates: Signature_____ Date_____ Signature_____ Date_____ Signature_____ Date_____

Signature_____ Date_____ Signature_____ Date_____ Signature_____ Date_____

Signature_____ Date_____ Signature_____ Date_____ Signature_____ Date_____