



Zuidema & Hess

Family and Cosmetic Dentistry

WELCOME TO OUR OFFICE!

1 : A COUPLE QUESTIONS ABOUT YOU

Today's Date: ____ / ____ / ____

Name: _____
FIRST MIDDLE LAST

Preferred Name: _____ Male Female

Home Address: _____

_____ CITY STATE ZIP CODE

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Email Address: _____

Birthday: ____ / ____ / ____ Age: ____

Social Security #: _____

Employer: _____

Occupation: _____

Who can we thank for referring you to our office?

Family _____ Friend _____ Internet _____

Yellow Pages _____ Radio _____ Other _____

Other family members seen by us: spouse children parents siblings

Names: _____

In the event of an emergency, whom should we contact?

Their name: _____ Phone #: _____ Relationship: _____



2 : DENTAL INSURANCE

Do you have dental insurance? **yes** **no**

Insured Name: _____

Insured SS#: _____

Insured Date of Birth: ____ / ____ / ____

Insured Employer: _____

Insurance Co. Name: _____

Insurance ID #: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (plan, local, or policy): _____

Secondary Dental Insurance

If patient has secondary dental insurance and patient is covered under the policy, complete the following:

Insurance Co. Name: _____

Insurance ID #: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (plan, local, or policy): _____

Spouse's Name: _____

Insured Date of Birth: ____ / ____ / ____ SS#: _____

Spouse's Employer: _____

Please list other family members covered by this dental insurance:

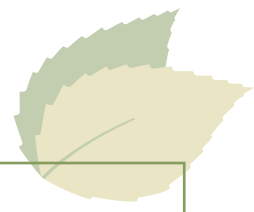
AUTHORIZATION

I hereby authorize payment directly to Dr. Lee Zuidema and Dr. Jeremy Hess 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 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 payers and/or other health professionals. **In the event that a health care worker comes in contact with my blood or other potentially infectious bodily fluids while treating me, I hereby consent to a hepatitis and HIV antibody test.** These tests will be at no charge to myself.

X _____

Date: ____ / ____ / ____

SIGNATURE I understand that typing my first and last name constitutes a legal electronic signature.



3 : MEDICAL HISTORY

Patient's Name: _____

Physician's Name: _____

Phone #: _____ Date last seen: ____/____/____

Your current physical health is: good fair poor

List any prescription or over-the-counter drugs you are taking:

List any herbal supplements you are taking:

Are you allergic to any of the following?

Penicillin	yes
Tetracycline	yes
Erythromycin	yes
Codeine	yes
Sulfa	yes
Ibuprofen	yes
Aspirin	yes
Dental Anesthetics (<i>Novocaine, Epinephrine, etc.</i>)	yes
Latex	yes
Metals	yes
Acrylic	yes

Please list any other drugs / foods / compounds that you are allergic to:

For Women:

Are you taking birth control pills?	yes
Are you pregnant?	yes (week #____)
Are you nursing?	yes

For Men:

Do you take nitroglycerin?	yes
Are you taking Viagra?	yes

Have you ever had any of the following diseases or medical problems?

Heart Attack	yes
Heart Murmur	yes
Heart Surgery	yes
Congenital Heart Defect	yes
Mitral Valve Prolapse	yes
Pacemaker	yes
Rheumatic Fever	yes
High Blood Pressure	yes
Low Blood Pressure	yes
Artificial Valves	yes
Atrial Fibrillation	yes
Stroke	yes
Hemophilia / Blood Disorder	yes
Blood Transfusions	yes
HIV + / AIDS	yes
Anemia	yes
Acid Reflux	yes
Tuberculosis	yes
Asthma	yes
Difficulty Breathing	yes
Emphysema	yes
Sleep Apnea	yes
Radiation	yes
Cancer / Chemotherapy	yes
Shingles	yes
Kidney Disease	yes
Artificial Bones / Joints	yes
Diabetes	yes
Hepatitis	yes
Psychiatric Problems	yes
Epilepsy / Seizures	yes
Cold Sores / Herpes	yes
Drug / Alcohol Addiction	yes
Venereal Disease	yes
Ulcers / Colitis	yes
Arthritis	yes
Frequent Headaches	yes
Sinus Problems	yes
Glaucoma	yes

Please list any serious medical condition(s) past or present:

