

**Patient
Information**
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Dr. Stelianos Bredologos, D.D.S.

Date _____

New Patient Update

PATIENT INFORMATION

Patient Name (Last)		(First)		(MI)	Social Security Number	
Home Address: Street				Apt. No.	City	
State	Zip Code	Home Phone ()	Work Phone ()	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
How did you hear about our office? <input type="checkbox"/> Friend (Name _____) <input type="checkbox"/> Physician Referral (DR _____) <input type="checkbox"/> Insurance <input type="checkbox"/> Verizon Yellow Pages <input type="checkbox"/> Community Red Phonebook <input type="checkbox"/> Yellow Book <input type="checkbox"/> Established <input type="checkbox"/> Other _____ Whom should we thank for your referral? _____				Would You Like to Receive Information by E-Mail? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, E-Mail Address: _____		
				Are you currently taking medications: Please List _____ _____ Physician Name _____ Number _____		

INSURANCE INFORMATION

Insurance ID No. (Member/Certificate)	Plan Name	Plan No.	Group No.
Subscriber Name <small>(The primary name in which the insurance policy is held)</small>		Employer	Effective Date
Social Security Number	Subscriber Date of Birth	Patient's Relationship to Subscriber <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Self <input type="checkbox"/> Other _____	

PARENT / GUARANTOR

(PERSON FINANCIALLY RESPONSIBLE FOR BILLS AFTER INSURANCE COMPANY PAYMENT)

Patient's Relationship to Guarantor: <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other _____			
Guarantor Name		Social Security Number	
Home Address: Street	City	State	Zip Home Phone ()
Work Phone	Cell Phone ()	Alternate Phone ()	
Employer Name and Address			
Name of Spouse		Social Security Number	
Employer Name and Address	Home Phone ()	Work Phone ()	Cell Phone ()

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature _____ Date _____

IN CASE OF EMERGENCY, PLEASE CONTACT: (Local – other than parent)

Name	Relationship	Phone Number
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Medical History

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

- | | | |
|--|---------------------------------|----------------------------------|
| Y N Abnormal Bleeding | Y N Hepatitis | Y N Frequent Headaches |
| Y N Alcohol / Drug Abuse | Y N Herpes / Fever Blisters | Y N Sickle Cell Disease / Traits |
| Y N Anemia | Y N High Blood Pressure | Y N Glaucoma |
| Y N Arthritis | Y N HIV+ / AIDS | Y N Sinus Problems |
| Y N Artificial Bones / Joints / Valves | Y N Hospitalized for Any Reason | Y N Hay Fever |
| Y N Asthma | Y N Kidney Problems | Y N Stroke |
| Y N Blood Transfusion | Y N Liver Disease | Y N Heart Attack |
| Y N Cancer / Chemotherapy | Y N Low Blood Pressure | Y N Thyroid Problems |
| Y N Colitis | Y N Mitral Valve Prolapse | Y N Heart Murmur |
| Y N Congenital Heart Defect | Y N Pacemaker | Y N Tuberculosis (TB) |
| Y N Diabetes | Y N Psychiatric Problems | Y N Heart Surgery |
| Y N Difficulty Breathing | Y N Radiation Treatment | Y N Ulcers |
| Y N Emphysema | Y N Rheumatic / Scarlet Fever | Y N Hemophilia |
| Y N Epilepsy | Y N Seizures | Y N Venereal Disease |
| Y N Fainting Spells | Y N Shingles | |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following drugs?

- | | |
|------------------|------------------------|
| Y N Penicillin | Y N Dental Anesthetics |
| Y N Aspirin | Y N Codeine |
| Y N Erythromycin | Y N Latex |
| Y N Tetracycline | Y N Other |

Please List any other drugs you are allergic to: _____

For Women:

- Are you taking any birth control pills? Yes No
Are you pregnant? Yes No Week #: _____
Are you nursing? Yes No

Dental History

- Last dentist visit date: _____
Do you require antibiotics before treatment? Yes No Arc you currently in pain? Yes / No
Have you ever had a serious / difficult problem associated with any previous dental work? Yes / No
Do you smoke or use tobacco in any other form? Yes / No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment with my informed consent.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.