WELCOME

CARY G. BLUMBERG, DDS, FICD
BLUMBERG FAMILY DENTAL CARE

Thank you for visiting us. We want your appointment to be pleasant and comfortable. Please help us by completing the form. If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION DATE:_____

NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

BIRTHDATE:_____/_____/_____SOC SEC#:_____HOME PHONE:_____

EMAIL ADDRESS:_____CELL PHONE:_____

EMPLOYER:_____WORK PHONE:_____

WORK ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

O SINGLE O ENGAGED O MARRIED O DIVORCED O SEPARATED O WIDOWED O MINOR

ACCOUNT INFORMATION (PERSON RESPONSIBLE FOR BILLING)

NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

BIRTHDATE:_____/_____/_____SOC SEC#_____HOME PHONE:_____

EMPLOYER:_____WORK PHONE:_____

WORK ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

Who may we thank for referring you to our office?_____

Do you have Dental Insurance? O Yes O No

ABOUT FINANCIAL ARRANGEMENTS

Payments for services are due at the time services are rendered, unless other payment arrangements have been approved in advance by our staff. We accept cash, check, MasterCard, Visa, Discover, American Express and CareCredit. Please note balances older than 60 days will subject to an interest charge of 1.5% per month. Charges may be incurred for broken appointments and appointments cancelled without 24 hours in advanced notice.

AUTHORIZATION

I hearby 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 hearby 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 medical history are correct to the best of my knowledge.

IN CASE OF EMERGENCY THE PERSON TO CALL

NAME:_____BEST CONTACT NUMBER(S):_____

ADDRESS:_____CITY:_____STATE:_____ZIPCODE:_____

SIGNATURE OF RESPONSIBLE PARTY

X_____DATE:_____

CHECK MARK IF: PATIENT:_____ PARENT____ SPOUSE:_____ GUARDIAN:_____

DENTAL HISTORY

What is the reason for your visit today?-

_____

Previous Dentist's
Name:_____Address:_____

Date of last dental visit:_____Date of your last teeth cleaning:_____ Date of last x-rays:_____

Do you use an electric toothbrush? If so, what type?_____

Is there anything about your dental treatment that you would like us to know?_____

_____

Are any of your teeth sensitive to:

Hot or Cold?	O Yes	O No
Sweets?	O Yes	O No
Biting or pressure?	O Yes	O No

Have you noticed:

Any foul Mouth odors or bad taste?	O Yes	O No
Frequent cold sores?	O Yes	O No
Gums bleed or hurt?	O Yes	O No
Your parents have/had gum disease or tooth loss?	O Yes	O No
Any loose teeth or change in your bite?	O Yes	O No
Your food tends to become caught between your teeth?	O Yes	O No

Do you:

Clench or grind your teeth while awake or asleep?	O Yes	O No
Have tired jaws, especially in the morning?	O Yes	O No
Bite your lips or cheeks often?	O Yes	O No
Hold foreign objects with your teeth? (pens, nails, paperclips, pipe)	O Yes	O No
Mouth breathe while asleep or awake?	O Yes	O No
Snore?	O Yes	O No
Do you use a CPAP machine?	O Yes	O No
Like the appearance of your teeth?	O Yes	O No
Like the color of your teeth?	O Yes	O No
Feel anxiety about dental treatment?	O Yes	O No

Have you ever experienced?

Clicking or popping of the jaw?	O Yes	O No
Pain? (joint, ear, side of face)	O Yes	O No
Difficulty opening or closing the mouth?	O Yes	O No
Frequent headaches, neck aches, or shoulder aches?	O Yes	O No
Any pain or soreness in the muscles of your face or around the ears?	O Yes	O No

Have you ever had?

An upsetting dental experience?	O Yes	O No
Orthodontic treatment?	O Yes	O No
Serious injury to the head or jaw?	O Yes	O No
Oral Surgery?	O Yes	O No
Removable Partial?	O Yes	O No
Complete Denture?	O Yes	O No
Fixed Bridge?	O Yes	O No
Implants?	O Yes	O No
Periodontal Treatment?	O Yes	O No
Gum Surgery?	O Yes	O No

If so, when? _____

Do you like the appearance of your smile?	O Yes	O No
Are your teeth as straight as you would like?	O Yes	O No
Would you be interested in anxiety free dentistry?	O Yes	O No

What would you like to change the most in the appearance of your teeth?_____

_____

_____

What would your ideal dental experience be like?_____

_____

_____

Do you have any dental problems or concerns not listed above? O Yes O No
if so, explain:_____

_____

I consent to the Dr.'s exam, diagnostics and x-rays

Patient Signature:_____ Date:_____
(Parent or Guardian)

Reviewed By:_____ Date:_____

MEDICAL HISTORY

List ALL medications including prescription, over-the-counter medications, vitamins and supplements:_____

_____

_____

Name:_____ Date:_____

Are you currently under the care of a Physician? O Yes O No If yes, for what reason?_____

Physician's Name:_____ Phone Number:_____

Physician's Address:_____ State:_____ Zip Code:_____

Certain medications can affect your dental health. Please answer these questions, to assist us in assessing your treatment.

Have you ever taken prescription drugs for weight loss? O Yes O No
Have you ever taken medications for Osteoporosis? O Yes O No
Are you, or have you ever taken any "blood thinners"? O Yes O No
Do you currently, or have you had to, take antibiotics before dental treatment? O Yes O No

ALLERGIES

Allergies and sensitivities are experienced by many people. An adverse reaction may be characterized by itching, rash, wheezing, vomiting, diarrhea, dizziness, swelling and irregular heartbeat. ***Please check all substances which may have caused you an adverse reaction, or are a known allergy.***

O Penicillin O Codeine O Local Anesthetic O Other _____
⊙ Aspirin O Other Antibiotics O Other Medications O Latex

Have you had any unusual or unexplained reactions during a surgical procedure? O Yes O No Please explain:_____

For Women: Are you pregnant? O Yes O No
Have you smoked in the past? O Yes O No
Do you currently smoke? O Cigarettes O Cigars O Pipe O Chew O Other
If so, how long ago? _____
Have you had any serious illness, hospitalization or accident? _____

Do you have, or have you ever had any of the following? Please check mark yes or no, as appropriate.

Heart Disease/Surgery	O Yes	O No	Asthma	O Yes	O No	Artificial Joint	O Yes	O No
Heart Murmur	O Yes	O No	Shortness of breath	O Yes	O No	Prosthetic Implants	O Yes	O No
Heart Pacemaker	O Yes	O No	Respiratory Ailments	O Yes	O No	Cancer	O Yes	O No
Rheumatic Fever	O Yes	O No	Tuberculosis	O Yes	O No	Radiation Therapy	O Yes	O No
Congenital Heart Disease	O Yes	O No	Sinus Trouble	O Yes	O No	Organ Transplant	O Yes	O No
Chronic Cough	O Yes	O No	Prolonged Bleeding	O Yes	O No	Glaucoma	O Yes	O No
Hepatitis A	O Yes	O No	Hepatitis B	O Yes	O No	Hepatitis C	O Yes	O No
Ulcers	O Yes	O No	Acid Reflux	O Yes	O No	Bulimia	O Yes	O No
Anorexia	O Yes	O No	Anemia	O Yes	O No	Kidney Problems	O Yes	O No
Fibromyalgia	O Yes	O No	Thyroid Problems	O Yes	O No	Diabetes	O Yes	O No
Mitral Valve Prolapse	O Yes	O No	Leukemia	O Yes	O No	Cortisone	O Yes	O No
High Blood Pressure	O Yes	O No	Low Blood Pressure	O Yes	O No	Sleep Apnea	O Yes	O No
HIV positive/AIDS	O Yes	O No	Epilepsy	O Yes	O No	Osteoporosis	O Yes	O No
Liver Disease	O Yes	O No	Blood Transfusion	O Yes	O No	STD's	O Yes	O No
Spleen Removal	O Yes	O No	Gall Bladder Removal	O Yes	O No	Lupus	O Yes	O No

DR. COMMENTS:_____

_____

O Premedication required

I understand the above information is necessary to provide me with the best dental care in a safe an effective manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask my health care provider or agency, who may release such information to you. I will notify this doctor of my changes in health or medication.

Patient's Signature _____ **Date**_____

INSURANCE HOLDER INFORMATION

Insurance Company name:_____

Insured Employer Name:_____

Patient Name:_____

Insurance Member #:_____ Group #:_____

Social Security #:_____ Birth Date:_____

Dependents Names:_____

Full Time College Student O Yes O No

If so, Name and Address of School:_____

Secondary Insurance Company Name:_____

Social Security # of Policy Holder:_____ Birth Date:_____

Insurance Member #:_____ Group #:_____

Employer Name:_____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Employer Telephone:_____

Please read and sign below:

Filing of insurance is courtesy we happily extend to our patients. Please be aware any insurance estimates quoted are only an estimate and not a guarantee of benefits. Insurance claims are submitted electronically within 24 hours of your visit. Please note any additional information requested by Insurance companies is submitted within 72 hours, from time the Explanation of Benefits is received. We allow up to 90 days to receive payment from Insurance companies. Balances older than 90 days are subject to a 1.5% finance charge. Balances over 120 days will be the full responsibility of the patient.

Signature of Responsible Party:_____

Date:_____