PATIENT INFORMATION

Date _____

Patient's Name _____
Last First Middle

Birth Date _____ Social Security #_____ Gender _____ Marital Status _____

Address _____
Street City Zip

Home #_____ Work #_____ Cell #_____

Email Address _____ Employer _____ Occupation _____

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

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's SS#_____ Birth Date_____

Insurance Company_____ ID#_____ Group#_____

Insurance Co. Address _____ Phone #_____

If you are covered by additional insurance, please complete the following:

Insured's Name _____ Insured's SS#_____ Birth Date_____

Insurance Company_____ ID#_____ Group#_____

Insurance Co. Address _____ Phone #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance coverage and assign directly to Dr. Cristina Nastea all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions.

Signature _____

EMERGENCY INFORMATION

Name of emergency contact _____
Home #_____ Work #_____ Cell #_____ Relationship to pt. _____

To the best of my knowledge, all of the preceding information provided is true and correct.

Signature _____
(Patient, parent or guardian)

MEDICAL HISTORY

Physician _____ Date of last visit _____
Address _____ Phone _____

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you taking any medications?_____
Yes No Are you allergic to any medication?_____
Yes No Do you have a history of major illness?_____
Yes No Have you had any operations?_____
Yes No Have you ever been involved in a serious accident?_____
Yes No Have you ever smoked or chewed tobacco?_____
Yes No Have you seen a physician in the last 12 months? Why?_____
Female patients only:
Yes No Are you pregnant?_____
Yes No Are you nursing?_____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding	Diabetes	Hepatitis/Liver Problems	Prolonged Bleeding
Anemia	Dizziness	High Blood Pressure	Psychiatric Treatment
Asthma	Epilepsy	HIV/Aids	Stroke
Arthritis	Heart Problems	Kidney Problems	Sinus Problems
Artificial Joints	Heart Murmur	Nervous Problems	Tuberculosis
Congenital Heart Defect	Hemophilia	Pneumonia	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?_____
_____

DENTAL HISTORY

Date of last visit?_____
What concerns you most about your teeth?_____

Yes No Are you presently in any dental pain?_____
Yes No Have you ever experienced any unfavorable reaction to dentistry?_____
Yes No Have your wisdom teeth been removed?_____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have there been any injuries to face, mouth or teeth?_____
Yes No Is any part of your mouth sensitive to temperature? Where?_____
Yes No Is any part of your mouth sensitive to pressure? Where?_____
Yes No Do your gums bleed when you brush?_____
Yes No Do you have any type of thumb or tongue habit?_____
Yes No Are you a mouth breather?_____
Yes No Have you ever seen an orthodontist? If yes, who and when?_____
Yes No Do your teeth or jaw ever feel uncomfortable when you wake in the morning?_____
Yes No Are you aware of your jaw clicking or popping?_____
Yes No Are you aware of clenching your teeth during the day?_____
Yes No Have you ever been told that you grind your teeth?_____
Yes No Do you have “tension” headaches?_____
Yes No Have you ever experienced chronic ringing in your ears?_____

Signature:_____ Date:_____

HIPAA

CONTACT INFORMATION AND AUTHORIZATION

Please provide us with the following information to help us serve you better.

I give permission for Dr. Cristina E. Nastea, to contact me in the following ways to **schedule appointments, to confirm appointments, give X-rays result, Etc:**

___Home phone# _____

___Cell phone # _____

___Work phone# _____

___Fax Number# _____

___E-Mail _____

I give permission for my Personal Health Information **(PHI)** to be discussed with the following people: for example – leave x-ray result, pick prescriptions, lab work, etc.

Name	**Relationship**	**Restriction if any**

Specific Authorization

_____**I give** permission to Dr. Cristina E. Nastea, to use my x-rays or photos for internal marketing or education.

_____**I DO NOT** give permission to Dr. Cristina E. Nastea, to use my x-rays or photos for internal marketing or education.

Appointments

As a courtesy to our patients we reserve time for your appointment. If you need to cancel or re-schedule your appointment **a 48- hour notice** is required. Otherwise a **$65 fee** will be charged.

Date: _____ Signature: _____