MICHAEL J. SPITZER, D.D.S.

PATIENT INFORMATION AND HEALTH HISTORY

We are complimented that you have selected us to provide dental care for you and your family,
So that we can serve you better, please complete both sides of this new patient information and health history form.

PERSONAL INFORMATION

PATIENT NAME________ DATE OF BIRTH________
IF CHILD, RESPONSIBLE PARTY NAME________ S.S.# ________
ADDRESS ________ PHONE ( ) ________
E-MAIL________
CITY________ STATE ________ ZIP________ OWN/RENT____ HOW LONG?____
PATIENT/PARENT EMPLOYED BY________ PHONE ( ) ________
BUSINESS ADDRESS________ ZIP________
PRESENT POSITION________ HOW LONG?________
IF PATIENT IS STUDENT, NAME OF SCHOOL________
NAME OF SPOUSE________ SPOUSE SS # ________
SPOUSE'S EMPLOYER________ PHONE ( ) ________
BUSINESS ADDRESS________ ZIP________
NEAREST RELATIVE________ ADDRESS ________
HOW DID YOU HAPPEN TO CHOOSE OUR OFFICE?________

DENTAL INSURANCE INFORMATION (if applicable)

PRIMARY CARRIER	SECONDARY CARRIER
INSURANCE CO. ________	INSURANCE CO. ________
GROUP # ________	GROUP # ________
EMPLOYEE ________	EMPLOYEE ________
RELATIONSHIP TO PATIENT________	RELATIONSHIP TO PATIENT________
EMP. SOC. SEC. # ________	EMP. SOC. SEC. # ________
EMP. DATE OF BIRTH________	EMP. DATE OF BIRTH________

MEDICAL INFORMATION

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE

Anemia
Diabetes (Date of onset: ______)
Epilepsy or Seizures
(Last occurence: ______)
Arthritis or Osteoporosis
Hepatitis (When: ______)
Fever Blisters or Cold Sores
Cortisone Medicine
Drug Problems
Hemophilia
Sinus Trouble or Asthma
Fungal Infections
Kidney Problems
Urinary Infections

Joint Replacement
Bullemia or Anorexia
Use of Cocaine (affects dental anesthetic)
Rheumatic Fever
Stroke or Angina (When: ______)
Heart Murmur
Congential Heart Lesions
Abnormal Heart Condition
High (or low) Blood Pressure
(S ______ /D ______)
Abnormal or Prolonged
Bleeding From A Cut
Herpes (1) or (2)
Psychiatric Treatment

Mononucleosis
AIDS/ARC
Epstein-Barr Virus (EBV)
Gonorrhea or Syphilis
Tuberculosis (TB)
Fainting Spells
Blood Transfusions
White Patches in the Mouth
ALLERGIES:
Penicillin or Erythromycin
Local Anesthetic
Aspirin/Valium/Pollen
Other Medication or Drugs
Women: Are you pregnant?

HEALTH UPDATE			
Yes	No	Initial:	Date:
Yes	No	Initial:	Date:
Yes	No	Initial:	Date:
Yes	No	Initial:	Date:
Yes	No	Initial:	Date:
Yes	No	Initial:	Date:

(Your responses are totally confidential)

PLEASE COMPLETE BACK PAGE

MEDICAL INFORMATION (Continuted)

ARE YOU TAKING ANY MEDICATION?________ IF SO, NAME OF MEDICATION________________________________

ANY OTHER PHYSICAL CONDITIONS WE SHOULD KNOW ABOUT?________________________________

________________________________ DATE OF LAST PHYSICAL EXAM________________

HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS?________ IF SO, FOR WHAT REASON?________________

____

ARE YOU RECEIVING OTHER HEALTH CARE NOW?________ IF SO, NATURE OF CARE________________

____

NAME OF PHYSICIAN________________________________ PHONE ________________

DENTAL INFORMATION

DO YOUR GUMS BLEED WHEN YOU BRUSH? YES ____ NO ____

DO YOU EVER HAVE BAD BREATH OR A BAD TASTE IN YOUR MOUTH? YES ____ NO ____

ARE YOUR TEETH SENSITIVE TO HEAT OR COLD? YES ____ NO ____

ARE YOUR TEETH SENSITIVE TO PRESSURE? YES ____ NO ____

ARE YOUR TEETH SENSITIVE TO SWEETS? YES ____ NO ____

DO YOU GRIND OR CLENCH YOUR TEETH? YES ____ NO ____

DO YOU HAVE ANY FEAR OF DENTAL WORK? YES ____ NO ____

DATE OF LAST DENTAL EXAMINATION________ WHAT WAS DONE AT THAT TIME?________________

____

HOW WOULD YOU DESCRIBE YOUR CURRENT DENTAL PROBLEM?________________________________

____

HOW WOULD YOU LIKE TO SEE US CORRECT YOUR DENTAL PROBLEM?________________________

____

HAVE YOU EVER HAD A BAD DENTAL EXPERIENCE?________________________________

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH?________________________________

____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge or 1½ % per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I have read the above conditions of treatment and agree to their content:

Signed:____ Date:________________

CONSENT FOR TREATMENT

I hereby grant complete authority to Dr. Spitzer to administer such anesthetics, analgesics, nitrous oxide, and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

Signature:____ Date:________________

(Relationship to patient if patient is a minor or mentally handicapped.)