Allen A. Ressler, D.D.S., Andrew R. Hirschl, D.D.S. Ira S. Lelchuk, D.D.S.

PATIENT INFORMATION

(PLEASE PRINT)

MR. MS.
NAME MRS. DR. _____ AGE _____ DATE _____

BIRTHDATE _____ HOME PHONE _____ CELL _____ E-MAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: ❑ MINOR ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

PATIENT'S OR PARENT'S NAME OF EMPLOYER _____ WORK PHONE _____

OCCUPATION _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL OR COLLEGE _____ CITY _____ STATE _____

Full-Time ❑ Yes ❑ No

WHOM MAY WE THANK FOR REFERRING YOU? PATIENT OF OUR OFFICE _____

REFERRING DOCTOR _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____

EMPLOYER NAME _____ WORK PHONE _____

EMPLOYER ADDRESS _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ❑ YES ❑ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # OF INSURED _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP# _____ UNION OR LOCAL# _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY SECONDARY INSURANCE? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY # OF INSURED _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP# _____ UNION OR LOCAL# _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION (S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATIONS(S) ARE YOU TAKING? _____		
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (EG. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	LATEX RUBBER
☐	☐	SULFA DRUGS	☐	☐	IODINE	☐	☐	OTHER _____

8. WOMEN ONLY:

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

9. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS
☐	☐	HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED
☐	☐	RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	SWOLLEN ANKLES	☐	☐	ARTIFICIAL HEART VALVE	☐	☐	HAY FEVER / ALLERGIES
☐	☐	FAINTING / SEIZURES	☐	☐	ANGINA	☐	☐	TUBERCULOSIS
☐	☐	ASTHMA	☐	☐	FREQUENTLY TIRED	☐	☐	RADIATION THERAPY
☐	☐	LOW BLOOD PRESSURE	☐	☐	ANEMIA	☐	☐	GLAUCOMA
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	EMPHYSEMA	☐	☐	RECENT WEIGHT LOSS
☐	☐	LEUKEMIA	☐	☐	CANCER	☐	☐	LIVER DISEASE
☐	☐	DIABETES	☐	☐	ARTHRITIS	☐	☐	HEART TROUBLE
☐	☐	KIDNEY DISEASES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	RESPIRATORY PROBLEMS
☐	☐	AIDS OR HIV INFECTION	☐	☐	HEPATITIS / JAUNDICE	☐	☐	MITRAL VALVE PROLAPSE
☐	☐	THYROID PROBLEM	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER
			☐	☐	STOMACH TROUBLES / ULCERS			

COMMENTS

DOCTORS USE ONLY:

PAYMENT ALTERNATIVES

1. Payment is expected at time of service. Cash, personal checks, Mastercard, Visa, American Express and Discover are accepted as methods of payment.
2. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. As another service to you, we accept assignment of your insurance payment. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.
3. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we also have available a dental financing plan. Once accepted you will have the option of selecting a payment plan.

Consent For Treatment

This is to verify that I, the undersigned, hereby authorize Drs. Ressler / Hirschl / Lelchuk and their hygienists / assistants to perform whatever examination or treatment deemed necessary and to the use of an anesthetic (or analgesic) as indicated and that the medical history I have given is correct.

On rare occasions, some unusual, unexpected and severe reactions or complications can occur, but we feel it would be impractical and misleading to describe in detail all those that could arise during or following treatment. Your doctor is aware of these risks and feels that the indications for treatment and benefits vastly outweigh the possible risks of the procedure. If you have further questions, please feel free to ask us before the procedure is begun.

INSURANCE: To avoid misunderstanding regarding insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that the patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of fee. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

_____ DATE

_____ SIGNATURE

_____ WITNESS

_____ RELATION TO PATIENT