Dr. Michael Katsev D.D.S
3478 Bridgeland Drive, Suite 3
Bridgeton, MO 63044

PATIENT INFORMATION

Patient's Name _____ Birthdate _____

(If CHILD) Parent's Name _____ SS# _____

Address _____ Home Phone _____

City _____ Cell Phone _____

State/Zip _____ Email _____

Person Responsible for this Account** _____

Primary Insurance Information

Name (of primary insurance holder) _____

SS# (of insurance holder) _____

Birthdate (of insurance holder) _____

Employer _____

Name of Insurance Company _____

Insurance Company Mailing Address for Claims _____

City, State/Zip _____

Insurance Phone # _____

Secondary Insurance Information

Name (of secondary insurance holder) _____

SS# (of Insurance Holder) _____

Birthdate (of Insurance Holder) _____

Employer _____

Name of Insurance Company _____

Insurance Mailing Address for Claims _____

City, State/Zip _____

Insurance Phone # _____

Phone (314) 291-2573
Fax (314) 291-9355
mkatsevdds@gmail.com

Medical History Information

Do you have, or have you had, any of the following:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's disease
- ☐ Anaphylaxis
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Disorder
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy/Seizers
- ☐ Fainting Spells/Dizziness
- ☐ Hay Fever
- ☐ Heart Attack/Heart Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Reflux
- ☐ Rheumatic Fever
- ☐ Scleroderma
- ☐ Thyroid Disease
- ☐ Transplant
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

*Please list any other medical conditions:

_____

Are you allergic to any medications? (If so, which?) _____

List of medications patient is currently taking:

_____

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HIPAA ACKNOWLEDGEMENT

I Acknowledge That I have received a copy of the "Notice of Private Practices" and I understand I have a right to review prior to signing this document. You may refuse to sign this part of the document

Parent/Guardian Signature _____

Print Name _____

Date _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes.

Sign _____ Date _____

Sign _____ Date _____

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