HEALTH HISTORY AND PATIENT INFORMATION

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

PERSONAL INFORMATION

Patient's Name _____ Nickname _____ Age _____
Last First MI

Address _____
Number and Street City State Zip

Telephone (_____) _____ Cell (_____) _____

Date of Birth _____ Sex _____ Occupation _____ SS# _____

Name of Spouse or Significant Other _____

Name of Emergency Contact _____ Telephone (_____) _____

Name of your physician _____ Date last seen _____

Reason for coming to the dentist _____

INSURANCE INFORMATION

Are you covered by a dental insurance plan? Yes _____ No _____

Name of insurance _____ Group / Policy # _____

Name of insurance policy holder _____ Social Security # _____

His/Her Date of birth _____ Have you received prefious dental care under this plan? Yes _____ No _____

HISTORY INFORMATION

	YES	NO
1. Have you ever required hospitalization for more than 24 hours?	❒	❒
2. Have you had any surgeries within the last 5 years?	❒	❒
If yes, what? _____		
3. Do you have any food or medication allergies?	❒	❒
If yes, what? _____		
4. Are you currently taking any medication?	❒	❒
If yes, what? _____		
5. Have you ever been seen by a dentist before?	❒	❒
If yes, when was your last visit? _____		
Name of doctor _____		
6. Have you ever received any form of fluoride?	❒	❒
7. Do you brush your teeth daily?	❒	❒
If yes, how many times? _____		
8. Do you use toothpaste?	❒	❒
If yes, what kind? _____		
9. Have you been diagnosed with sleep apnea?	❒	❒
10. Do you or have you used CPAP?	❒	❒

Please provide the names and ages of your children _____

_____

Have you had any medical problems in the following areas? Please check all that apply.

- ❒ Blood
- ❒ Bones
- ❒ Endocrine
- ❒ Eyes, Ears, Nose, Throat
- ❒ Gastrointestinal
- ❒ Heart
- ❒ Kidney/bladder
- ❒ Liver
- ❒ Muscles
- ❒ Nervous System
- ❒ Skin
- ❒ Tonsils/Adenoids

❒ I have NOT had treatment for any of the above.

Has a physician ever diagnosed you with any of the following medical conditions? Please check all that apply.

- ❒ ADD/ADHD
- ❒ Allergy
- ❒ Arthritis
- ❒ Asthma
- ❒ Autism
- ❒ Brain injury
- ❒ Cancer
- ❒ Cerebral Palsy
- ❒ Cleft lip/palate
- ❒ Convulsions/seizures
- ❒ Developmental Delay
- ❒ Diabetes
- ❒ Emotional Disturbance
- ❒ Epilepsy
- ❒ Eye Problems
- ❒ Excessive Bleeding Problem
- ❒ Fainting
- ❒ Hearing Loss
- ❒ Heart Disease
- ❒ Heart murmur
- ❒ Hemophilia
- ❒ Hepatitis
- ❒ Leukemia
- ❒ Mental Retardation
- ❒ AIDS
- ❒ HIV
- ❒ Nutritional Deficiency
- ❒ Orthopedic Problems
- ❒ Rheumatic Fever
- ❒ Scoliosis
- ❒ Sickle Cell Anemia
- ❒ Spina Bifida
- ❒ Syndrome
- ❒ Other

❒ I have never been diagnosed as having any of the above conditions.

Is there anything else that you think we should know about you so that we may better meet your treatment needs?

_____

_____

_____ _____

Signature of patient Date

Do Not Write below this line

Medical History

_____

_____

SBE Recommendations

_____

_____

Dental History Summary

_____

_____

_____ _____

Doctor's Signature Date

mzl DENTAL

Lago, Zicherman & Associates

quality dentistry & orthodontics since 1975

I understand that I am financially responsible for all dental services rendered. As a courtesy, MZL Dental will submit insurance claims on my behalf.

All insurance claims that are not paid within ninety (90) days will become my responsibility and prompt payment is then expected.

Note: Estimated insurance payment is only an estimate and may not be accurate. It may vary according to the guidelines of my specific insurance policy. Any and all disputes, regarding a dental claim payment, are between you and your insurance company.

Thank you for your cooperation.

Signature _____ Date _____

Drs. Lago, Zicherman & Associates
quality dentistry & orthodontics since 1975

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Appointment Policy for General Dentistry

One of our chief goals is to provide you with the best care possible. We also realize many of our patients have busy lives and we do respect your valuable time. In order to ensure the best prognosis for your oral health we need to complete proposed treatment in a timely fashion. This requires the patient to keep the appointments that they make and to maintain punctuality. We want to be as fair as possible to all our patients, including you. We ask that you kindly not break your appointments not only for your own benefit, but also out of respect for other patients who would have gladly taken that appointed time. We have set out the following appointment policy for the benefit of **ALL** our patients:

1). If you must cancel an appointment, it must be done so **48 hours** in advance.
2). If you miss an appointment without notifying the office **48 hours** in advance you will be assessed a **minimum $60 fee**. Longer appointments will have a higher fee according to the allotted time for the procedure, and may require a deposit to hold the appointment. **This is a common policy at virtually all dental offices.**
3). Procedures that involve a longer appointment may require a 48-72 hour cancellation notice, and you will be reminded of this policy when you schedule such appointments.

By signing below you signify that you have read and understand the cancellation policy in our office and are aware of your responsibility to maintain regular appointments and any such fees associated with breaking this policy:

Signed_____ Date_____