Arnel Mariano, D.D.S.

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PATIENT INFORMATION

Date: _____ ID# or SS#_____

Patient: _____

Address: _____

_____
City State Zip

Sex: ❑ M ❑ F Age:_____Birthdate:_____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Birthdate: _____SS# _____

Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

_____

DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to Patient: _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscribers Name: _____

Birthdate: _____SS# _____

Relationship to Patient: _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with:

_____ and assign directly to Arnel Mariano, DDS, 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

_____
Responsible Party Signature

_____
Relationship Date

PHONE NUMBERS

Home ( ) Work ( ) Ext: Spouse's Work ( )

Best time and place to reach you

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name: Relationship:

Home Phone: ( ) Work Phone: ( )

DENTAL HISTORY

❑ Y=Yes ❑ N=No

Reason for today's visit? _____

_____

Former Dentist: _____

City / State: _____

Date of last dental visit: _____

Date of last dental x-rays: _____

Check (✓) all of the following that apply...

Bad Breath	❑ Y	❑ N
Bleeding Gums	❑ Y	❑ N
Blisters on lips or mouth	❑ Y	❑ N
Jaw pain or tiredness	❑ Y	❑ N

How often do you floss? _____

Burning sensation on tongue	❑ Y	❑ N
Chew on one side of mouth	❑ Y	❑ N
Cigarette, pipe, of cigar Smoking	❑ Y	❑ N
Clicking or popping jaw	❑ Y	❑ N
Dry mouth	❑ Y	❑ N
Fingernail biting	❑ Y	❑ N
Food collection between teeth	❑ Y	❑ N
Foreign objects	❑ Y	❑ N
Grinding teeth	❑ Y	❑ N
Gums swollen or tender	❑ Y	❑ N
Lip or cheek biting	❑ Y	❑ N

How often do you brush? _____

Loose teeth or broken fillings	❑ Y	❑ N
Mouth breathing	❑ Y	❑ N
Mouth pain, brushing	❑ Y	❑ N
Orthodontic treatment	❑ Y	❑ N
Pain around ear	❑ Y	❑ N
Periodontal treatment	❑ Y	❑ N
Teeth sensitive to cold	❑ Y	❑ N
Teeth Sensitive to heat	❑ Y	❑ N
Sensitive to sweets	❑ Y	❑ N
Sensitivity when biting	❑ Y	❑ N
Sores or growths in mouth	❑ Y	❑ N

HEALTH HISTORY

Physician's Name: _____Date of last visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes____ No____

Check (✓) if you have ever had or now have the following: ❑ Y=Yes ❑ N=No

AIDS / HIV	❑ Y ❑ N	Emphysema	❑ Y ❑ N	Radiation Treatment	❑ Y ❑ N
Anemia	❑ Y ❑ N	Epilepsy	❑ Y ❑ N	Respiratory Disease	❑ Y ❑ N
Arthritis, Rheumatism	❑ Y ❑ N	Fainting of dizziness	❑ Y ❑ N	Rheumatic Fever	❑ Y ❑ N
Artificial Heart Valves	❑ Y ❑ N	Glaucoma	❑ Y ❑ N	Scarlet Fever	❑ Y ❑ N
Artificial Joints	❑ Y ❑ N	Headaches	❑ Y ❑ N	Shortness of Breath	❑ Y ❑ N
Asthma	❑ Y ❑ N	Heart Problems or Murmur	❑ Y ❑ N	Sinus Trouble	❑ Y ❑ N
Back Problems	❑ Y ❑ N	Hepatitis Type: _____	❑ Y ❑ N	Skin Rash	❑ Y ❑ N
Bleeds abnormally easy	❑ Y ❑ N	Herpes	❑ Y ❑ N	Special Diet	❑ Y ❑ N
Blood Disease	❑ Y ❑ N	High Blood Pressure	❑ Y ❑ N	Stroke	❑ Y ❑ N
Cancer	❑ Y ❑ N	Jaundice	❑ Y ❑ N	Swelling of Feet or Ankles	❑ Y ❑ N
Chemical Dependency	❑ Y ❑ N	Jaw Pain	❑ Y ❑ N	Swollen Neck Glands	❑ Y ❑ N
Chemotherapy	❑ Y ❑ N	Kidney Disease	❑ Y ❑ N	Thyroid Problems	❑ Y ❑ N
Circulatory Problems	❑ Y ❑ N	Liver Disease	❑ Y ❑ N	Tonsillitis	❑ Y ❑ N
Congenital Heart Lesions	❑ Y ❑ N	Low Blood Pressure	❑ Y ❑ N	Tuberculosis	❑ Y ❑ N
Cortisone Treatments	❑ Y ❑ N	Mitral Valve Prolapse	❑ Y ❑ N	Tumor / growth on head/neck	❑ Y ❑ N
Cough, Persistent or bloody	❑ Y ❑ N	Nervous Problems	❑ Y ❑ N	Ulcer	❑ Y ❑ N
Diabetes	❑ Y ❑ N	Pacemaker	❑ Y ❑ N	Venereal Disease	❑ Y ❑ N
Do you wear contact lenses?	❑ Y ❑ N	Psychiatric Care	❑ Y ❑ N	Weight loss, unexplained	❑ Y ❑ N

Women:

Are you pregnant? ❑ Y ❑ N Due date_____ Are you nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name (_____)_____

ALLERGIES

❑ Aspirin
❑ Barbiturates (sleeping pills)
❑ Codeine
❑ Iodine
❑ Latex_____
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other_____
_____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ❑ Y ❑ N

For what condition? _____

Are you taking any new medications? _____ If so, what_____

Patient's Signature_____Date_____

Doctor's Signature_____Date_____

Has there been any change in your health since your last dental appointment? ❑ Y ❑ N

For what condition? _____

Are you taking any new medications? _____ If so, what_____

Patient's Signature_____Date_____

Doctor's Signature_____Date_____