ABOUT YOU

Today's Date: / / File #:

Patient Name: *(Last)*

(First) *(MI)*

What You Prefer To Be Called: Male___ Female___

Birth date: / / Age: SS #:

Mailing Address:

(City) *(State)* *(Zip)*

Home Phone #:

Work Phone #: Ext:

Cell Phone #:

DENTAL INFORMATION

Reason for today's visit: Exam _____ Emergency _____ Consultation _____

Are You in pain? Yes _____ No _____ How long? _____

Please, indicate any of the following problems: (√)

Discomfort, clicking or popping in the jaw _____

Red, swollen or bleeding gums _____

Sensitive tooth, teeth or gums _____

Blisters/Sores in or around the mouth _____

Lost/Broken Fillings _____

Teeth Grinding _____

Ringing in Ears _____

Broken/Chipped Tooth _____

Stained Teeth _____

Locking Jaw _____

Bad Breath _____

Other: _____

Do You require pre-medication? Yes ____ No _____ Don't know _____

We value your time and as such we appreciate your compliance with our 48 hour cancellation policy. Please be aware the 48 hour cancellation fee is $150. Please know we will opt to use the credit card on file to process this fee.

INSURANCE INFO

Primary Dental Insurance Co. Name:

Address:

(City)

(State) *(Zip)*

Phone #:

Insured's SS #:

Group # *(Plan, Local or Policy #)*:

Insured's Name:

Relation: Date of Birth: / /

Insured's Employer:

MEDICAL HISTORY

Are you taking any of the following medications?

Nerve pills ___

Pain killers (including aspirin)___

Muscle relaxers ___

Stimulants ___

Blood Thinners ___

Tranquilizers ___

Insulin ___

Other(s), _____

Please, list any other surgeries or medical conditions you have or ever had:

Are you allergic to any of the following?

Latex ___ Penicillin/Amoxicillin ___ Tetracycline ___ Aspirin ___ Dental Anesthetics ___ Others ___

Do you use tobacco? No ___ Yes/How used? _____ How much?_____ How long?_____

Please, rate your general health from 1-10: _____

Do you wear contact lenses? Yes _____ No _____

Have you ever taken the drug Phen-fen and/or Redux? Yes ___ No_____

For women: Are you taking Birth Control pills? Yes ___ No ___ How many children have you had? ____

Are you pregnant? No___ Yes_____ Are you nursing? Yes____ No____

Do you have or have you had any of the following diseases, medical conditions or procedures? PLEASE CIRCLE Y (YES) OR N(NO)

Y N	**Heart Attack/Stroke**	**Y N**	**Thyroid Problems**	**Y N**	**Cancer/Tumors**
Y N	**Heart Surgery/Pacemaker**	**Y N**	**Kidney Problems**	**Y N**	**Shingles**
Y N	**Heart Murmur**	**Y N**	**Liver problems**	**Y N**	**Hepatitis**
Y N	**Rheumatic Fever**	**Y N**	**Respiratory Problems**	**Y N**	**HIV+/AIDS/ARC**
Y N	**Mitral Valve Prolapse**	**Y N**	**Sinus problems**	**Y N**	**Arthritis/Rheumatism**
Y N	**Artificial Valves**	**Y N**	**Stomach Problems/Ulcers**	**Y N**	**Artificial Bones/Joints**
Y N	**Heart Disease**	**Y N**	**Psychiatric Problems**	**Y N**	**Emphysema**
Y N	**Congenital Heart Defect**	**Y N**	**Venereal Problems**	**Y N**	**Fainting/Seizures/Epilepsy**
Y N	**Chest pains**	**Y N**	**Alcohol/Drug Abuse**	**Y N**	**Severe/Frequent Headaches**
Y N	**Scarlet Fever**	**Y N**	**Tuberculosis TB**	**Y N**	**Frequent Neck Pain**
Y N	**Nervousness**	**Y N**	**Jaw Problems TMJ/TMD**	**Y N**	**Back Problems**

Y N	**Cosmetic Surgery**	**Y N**	Leukemia
Y N	**X-Ray or Cobalt Treatment**	**Y N**	Anemia
Y N	**Chemotherapy**	**Y N**	High/Low Blood Pressure
Y N	**Asthma**	**Y N**	Bleeding Problems
Y N	**Difficulty Breathing**	**Y N**	Glaucoma
Y N	**Diabetes/Hypoglycemia**		

Please read this as we wish to have a transparent relationship with our patients. Please note that a $25 charge will be posted to your account at every office visit. Please note that payment is expected at the time of service, unless other arrangements have been made for treatments only: not diagnostics- examinations and x-rays. As a Fee For Service practice we will process your insurance information and will provide you a claim to submit to your insurance plan. If you have not received payment within 2-3 weeks, please contact your insurance company. We are here to assist you in obtaining reimbursement according to your insurance policy. You may contact us by telephone or email, whichever is convenient. As our patient we are available 24 hours for emergency treatment. Please note there is a $395 additional charge for after hours emergency treatments. In case of an emergency which relates to oral and dental health Dr. Claudia Cotca is available to meet you at the Hospital. All fees apply.

I authorize Dr. Cotca and the Staff to perform any necessary services needed during diagnosis and treatment. I authorize provider to release information required to process insurance claims. I authorize Dr. Cotca and staff to contact my other medical and dental providers to obtain access to and discuss any related medical history information with past, current and future providers. My physicians and their contact information follows:

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_____

Signature_____ Date_____ Updates

DATE INITIALS PATIENT MED HISTORY CHANGE DR. SIGNATUR ADDRESS UPDATE / INSURANCE UPDATE

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Washington Institute Dentistry & Laser Surgery 202.997.4689 Dr. Claudia C. Cotca, DDS, MPH