ROGER H. ZENN, D.D.S.

WELCOME TO OUR PRACTICE!

Thank you for selecting our dental office. We will strive to provide you the best possible dental care. To help us meet your dental healthcare needs, please fill out **both sides** of this form completely in ink. This information you provide will help us serve you more effectively and efficiently. All information is completely confidential. If you have any questions or need assistance, please ask us—we are always happy to help.

TODAY'S DATE_____________________________________PATIENT'S EMAIL_____________________________

PATIENT NAME_____________________________________SPOUSE'S NAME_____________________________

STREET ADDRESS__________________________________CITY, STATE, ZIP _____________________________

HOME TELEPHONE_________________________________MOBILE TELEPHONE__________________________

EMPLOYER_____________________________BIRTHDATE_____________AGE_______SS#__________________

WORK ADDRESS__________________________________CITY, STATE, ZIP______________________________

Single, Married, Divorced, Widowed, Other

WORK TELEPHONE________________________________MARITAL STATUS______________________________

PERSON FINANCIALLY RESPONSIBLE________________________________RELATION TO PATIENT__________

EMPLOYER______________________________________OCCUPATION__________________________________

HOME ADDRESS_________________________________CITY, STATE, ZIP________________________________

BIRTHDATE_______________AGE______SS#_______________HOME TELEPHONE________________________

WORK ADDRESS_________________________________CITY, STATE, ZIP________________________________

WORK TELEPHONE___________________________________MOBILE TELEPHONE________________________

DENTAL INSURANCE

PRIMARY INSURANCE CARRIER___________________________________GROUP NUMBER_________________

EMPLOYEE______________________________________BIRTHDATE______________SS#___________________

INSURANCE COMPANY ADDRESS____________________________CITY, STATE, ZIP_______________________

SECONDARY INSURANCE CARRIER________________________________GROUP NUMBER_________________

EMPLOYEE______________________________________BIRTHDATE______________SS#___________________

INSURANCE COMPANY ADDRESS____________________________CITY, STATE, ZIP_______________________

FINANCIAL ARRANGEMENTS: For your convenience, we offer the following method of payment. Please circle the option which you prefer. If you have any questions concerning financial arrangements or special arrangements, please ask for assistance. **Payment in full is due at each visit.**

CASH PERSONAL CHECK CREDIT CARD: Visa Mastercard CARD #___________________Exp. Date_______

LATE CHARGES: If I do not pay the entire new balance within 30 days of the monthly billing date, a finance charge of 1.50% per month on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in us being unable to provide additional services except for dental emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

AUTHORIZATION AND RELEASE: I authorize **ROGER H. ZENN, D.D.S**. to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of al services rendered on my behalf or on behalf of my dependents.

DATE______________________PATIENT'S or PARENT'S SIGNATURE_____________________________________

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PATIENT MEDICAL HISTORY

PATIENT NAME____PHYSICIAN___________________________

PHYSICIAN'S OFFICE PHONE___________________________________DATE OF LATE EXAM__________________

1. Are you under medical treatment now? **Yes No**
2. Are you allergic to or have you had any reactions to the following:
   - Local Anesthetics (i.e., Novocaine) **Yes No**
   - Penicillin, or other antibiotics **Yes No**
   - Aspirin **Yes No**
   - Codeine **Yes No**
   - Sedatives and/or Barbiturates **Yes No**
   - Sulfa Drugs **Yes No**
   - Other (please list)__________________________ **Yes No**
3. Have you been hospitalize for any serious illness? **Yes No**
4. Are you taking any medication(s) including non-prescription medicine? **Yes No**

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5. Do you over-use alcohol, cocaine, or tobacco? **Yes No**
6. Have you ever had excessive bleeding? **Yes No**
7. Have you ever had cold sores on your lips or mouth area? **Yes No**
8. WOMEN ONLY:
   a. Are you pregnant or think you may be pregnant? **Yes No**
   b. Are you taking birth control pills? **Yes No**
9. Do you have or have you ever had any of the following?

High Blood Pressure **Yes No**	Heart Disease **Yes No**	Thyroid Problems **Yes No**
Heart Attack or Stroke **Yes No**	Cardiac Pacemaker **Yes No**	Rheumatic Fever **Yes No**
Heart Murmur **Yes No**	Fainting, Seizures or Epilepsy **Yes No**	Angina **Yes No**
Hay Fever or Allergies **Yes No**	Asthma **Yes No**	Radiation Therapy **Yes No**
Tuberculosis **Yes No**	Emphysema **Yes No**	Stomach Problems or Ulcers **Yes No**
Low Blood Pressure **Yes No**	Cancer **Yes No**	Recent Weight Loss **Yes No**
Herpes **Yes No**	Glaucoma **Yes No**	Liver or Kidney Disease **Yes No**
Joint Replacement or Implant **Yes No**	Arthritis **Yes No**	Respiratory Disease **Yes No**
Sinus Problems **Yes No**	Hepatitis **Yes No**	AIDS or HIV Infection **Yes No**
Mitral Valve Prolapse **Yes No**	Jaw Problems (TMJ) **Yes No**	Other_________________________ **Yes No**

10. Do you need to pre-medicate prior to dental treatments with antibiotics? **Yes No** If so, what antibiotics have been prescribed?____________

PATIENT DENTAL HISTORY

Previous Dentist___________________________________Address____________________________________Phone_________________

1. What was the date of your last dental visit?_____________________
2. What was the reason?___________________________________
3. Are your teeth sensitive to hot or cold liquids or food? **Yes No**
4. Can you chew on both sides of your mouth? **Yes No**
5. Are you teeth sensitive to sweet liquids or food? **Yes No**
6. Do you have sores or lumps in your mouth? **Yes No**
7. Do you feel pain in any of your teeth? **Yes No**
8. Do you grind or clench your teeth? **Yes No**
9. Have you ever had difficult extractions? **Yes No**
10. Have you ever had endodontic or root canal treatment? **Yes No**
11. Have you ever had oral surgery? **Yes No**
12. Have you ever had periodontal (gum) treatment? **Yes No**
13. Have you ever experienced any of the following in your jaw? Clicking or Noise **Yes No** Pain in your joint, ear of side of face **Yes No**

    Difficulty opening or closing your jaw? **Yes No**
14. Have you ever had an upsetting dental visit? **Yes No**
15. Would you like your smile whitened or improved? **Yes No**
16. Are you happy with the appearance of your teeth? **Yes No**
16. Are there any other comments, a main dental complaint, or anything else that you would like us to know about you regarding dental treatment?

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Whom may we thank you for referring you to our office?____