Welcome to Dr. Peyser's office

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Today's Date________________________ Birth Date________________________ Patient Social Security #________________________

Patient Name____
(Last Name) (First Name) (Initial)

Street Address____

City________________________ State________________________ Zip________________________

Occupation________________________ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Patient Home Phone________________________ Patient Work Phone________________________

Employer________________________ Employer Phone________________________

Employer Address____

In Case of Emergency Contact:

Name________________________ Relationship________________________

Emergency Home Phone________________________ Emergency Work Phone________________________

Whom may we may we thank for referring you to us?________________________

PRIMARY INSURANCE

Individual responsible for this account____
(Last Name) (First Name) (Initial)

Relationship to Patient________________________ Birth Date________________________ Social Security #________________________

Street Address________________________ Home Phone________________________

City________________________ State________________________ Zip________________________

Responsible Party Employed By________________________ Business Phone________________________

Business Address________________________ Occupation________________________

InsuranceCompany____

Insurance Company Address____

Subscriber I.D. #________________________ Group #________________________

ADDITIONAL INSURANCE

Insured Individual's Name____
(Last Name) (First Name) (Initial)

Relationship to Patient________________________ Birth Date________________________ Social Security #________________________

Street Address________________________ Home Phone________________________

City________________________ State________________________ Zip________________________

Insured Party Employed By________________________ Business Phone________________________

InsuranceCompany____

Insurance Company Address____

Subscriber I.D. #________________________ Group #________________________

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____ Date________________________

Payment is due in full at time of treatment unless prior arrangements have been approved.

FAMILY HEALTH INFORMATION

Some health conditions are the result of hereditary weaknesses. Information that you can furnish us pertaining to your immediate family members (brothers, sisters, parents and grandparents) will give us a better understanding of your health needs.

Relationship To You	Family Members Present and Past Health Problems

MEDICATIONS

List medications you are currently taking:

____

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Pharmacy_________________________ Phone___________________

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (Sleeping Pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other (please list)

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CHECK ANY SYMPTOM(S) OR CONDITION(S) BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR:

- ❑ AIDS
- ❑ Appendicitis
- ❑ Arm Pain or Numbness
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain or Numbness
- ❑ Bleeding Disorders
- ❑ Bleeding Gums
- ❑ Bloating
- ❑ Blood in Urine
- ❑ Blurred Vision
- ❑ Bowel Changes
- ❑ Breast Lump
- ❑ Brights Disease
- ❑ Bruises Easily
- ❑ Bursitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Change in Moles
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Chills
- ❑ Constipation
- ❑ Crossed Eyes
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Depression/Nervousness
- ❑ Difficulty Swallowing
- ❑ Dizziness/Fainting
- ❑ Double Vision
- ❑ Excessive Thirst
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Earache
- ❑ Ear Discharge
- ❑ Feet Pain or Numbness
- ❑ Fever
- ❑ Forgetfulness
- ❑ Frequent Urination
- ❑ Gas
- ❑ Glaucoma
- ❑ Hand Pain or Numbness
- ❑ Hay Fever
- ❑ Headache
- ❑ Heart Disease
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hip Pain or Numbness
- ❑ HIV Positive
- ❑ Hives
- ❑ Hoarseness
- ❑ Indigestion
- ❑ Irregular Heart Beat
- ❑ Itching
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Lack of Bladder Control
- ❑ Leg Pain or Numbness
- ❑ Liver Disease
- ❑ Loss of Hearing
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Low Blood Pressure
- ❑ Lumbago
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nausea
- ❑ Neck Pain or Numbness
- ❑ Neuralgia
- ❑ Neuritis
- ❑ Nose Bleeds
- ❑ Pacemaker
- ❑ Painful Urination
- ❑ Persistent Cough
- ❑ Pneumonia
- ❑ Polio
- ❑ Poor Appetite
- ❑ Poor Circulation
- ❑ Prostate Problem
- ❑ Rapid Heartbeat
- ❑ Rash
- ❑ Rectal Bleeding
- ❑ Rheumatic Fever
- ❑ Ringing in Ears
- ❑ Scarlet Fever
- ❑ Scars
- ❑ Sciatica
- ❑ Shoulder Pain or Numbness
- ❑ Sinus Problems
- ❑ Sore That Won't Heal
- ❑ Stomach Aches or Pain
- ❑ Stroke
- ❑ Sweats
- ❑ Swelling Ankles
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Vision Flashes
- ❑ Vomiting
- ❑ Vomiting Blood

CHECK DEGREE OF HABITS BELOW. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	HEAVY	CASUAL	LIGHT	NONE
Alcohol	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑
Coffee	❑	❑	❑	❑

	HEAVY	CASUAL	LIGHT	NONE
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sleep	❑	❑	❑	❑

	HEAVY	CASUAL	LIGHT	NONE
Soft Drinks	❑	❑	❑	❑
Sugar/Sugar Products	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Water	❑	❑	❑	❑

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature____ Date_____________________