

Dr. Daniel Balaze, D.M.D. Inc.

Welcome to our practice! We look forward to getting to know you and meeting your dental needs!

To help us meet all your healthcare needs, please fill out this form as completely as possible in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____
SS# _____ Birthdate _____
Home Phone _____ Cell Phone _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
E-mail _____
Check Appropriate Box: Minor Single Married Separated Divorced Widowed
Patient or Parent/Guardian's Employer _____
Business Address _____ City _____ State _____
If student, Name of School/College _____ City _____ State _____ Full Time Part
Time
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
How did you find us? _____
Person to contact in case of emergency _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
E-mail _____ Cell Phone _____
Birthdate _____
Employer _____ Work Phone _____ SS# _____
Is this person currently a patient in our office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Please note that Payment must be made in full at each appointment.

Cash Personal Check Credit Card VISA Mastercard I wish to discuss the office's payment policy

Insurance Information

Name of Insured _____ Relationship to patient _____
Birthdate _____ SS# _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Subscriber ID# _____
Ins.Co.Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Do you have any additional Insurance? YES NO If yes, complete the following

Name of Insured _____ Relationship to patient _____
Birthdate _____ SS# _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Subscriber ID# _____
Ins.Co.Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- Yes No
1. Are you under medical treatment now?
2. Have you ever been hospitalized for any surgical

 operation or serious illness within the last 5 years?

If yes, please explain _____

3. Are you taking any medication(s) including
 Non-prescription medicines/herbal remedies?
4. Have you ever taken Fen-Phen/Redux?
5. Do you use tobacco?
6. Do you use controlled substances?
7. Are you wearing contact lenses?

- Yes No
9. Are you allergic to or have you had any reactions to :
 Local Anesthetics (e.g. Novocain)
 Penicillin or any other Antibiotics

Sulfa Drugs
 Barbiturates
 Sedatives
 Iodine

Aspirin
 Any Metals
 Latex Rubber
 Other

10. Do you have persistent cough or throat clearing not
 Associated with a known illness?

11. Women only:

Are you pregnant or think you may be pregnant?

Are you nursing?

Are you taking oral contraceptives?

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problem	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- Yes No
1. Do your gums bleed while brushing or flossing?
2. Are your teeth sensitive to hot or cold liquids/foods?
3. Are your teeth sensitive to sweet or sour liquids/foods?
4. Do you feel pain to any of your teeth?
5. Do you have any sores or lumps in or near your mouth?
6. Have you had any head, neck or jaw injuries?
7. Have you ever experienced any of the following
 Problems in your jaw?
 Clicking
 Pain (Joint, ear, side of face)
- Yes No
8. Do you have frequent headaches?
9. Do you clench or grind you teeth?
10. Do you bite your lips or cheeks frequently?
11. Have you ever had any difficult extractions?
12. Have you ever had any prolonged bleeding
 following extractions?
13. Have you had any orthodontic treatment?
14. Do you wear dentures or partials?
 If yes, date of placement _____
15. Have you ever received oral hygiene instruction

Difficulty in opening or closing

regarding the care of your teeth and gums?

Difficulty in chewing

16. Do you like your smile? 😊

The above information is true and complete to the best of my knowledge. _____

[Please, sign and date.]