

WELCOME

MICHAEL B. WEXLER, DDS
7265 E. TANQUE VERDE RD., SUITE #101
TUCSON, AZ 85715
(520) 888-SMILE (7645) www.888-SMILE.com

PATIENT NAME: _____ HM #: _____ WK #: _____ CELL #: _____

(Please circle best # to reach you: HM WK Cell)

DOB: _____ SS #: _____ GENDER: M F MARITAL STATUS (CIRCLE): MARRIED SINGLE CHILD DIVORCED

E-MAIL ADDRESS _____

HOME ADDRESS: _____ CITY: _____ ZIP CODE: _____

IF PATIENT IS A CHILD, GUARDIAN'S NAME: _____ HM: _____ CELL#: _____

SPOUSE'S NAME: _____ WK#: _____ CELL #: _____

Nearest relative not living with you: _____ HM #: _____

Nearest friend not living with you: _____ HM #: _____

Whom may we thank for referring you to us? _____ HM #: _____

Whom may we contact in the case of an emergency? _____ HM #: _____

Who is responsible for the bill (PLEASE SUBMIT ANY FUTURE CHANGES IN WRITING) _____ HM #: _____

I WILL BE PAYING TODAY BY: CASH _____ CHECK _____ CREDIT CARD _____

INSURANCE

PRIMARY DENTAL INS. CO. NAME: _____ GROUP # (PLAN, LOCAL, OR POLICY #): _____

ADDRESS: _____ PHONE #: _____

INSURED'S NAME: _____ DOB: _____ SS #: _____ RELATION: _____

INSURED'S EMPLOYER: _____ PHONE #: _____

ADDRESS: _____

SECONDARY DENTAL INS. CO. NAME: _____ GROUP # (PLAN, LOCAL, OR POLICY #): _____

ADDRESS: _____ PHONE #: _____

INSURED'S NAME: _____ DOB: _____ SS #: _____ RELATION: _____

INSURED'S EMPLOYER: _____ PHONE#: _____

ADDRESS: _____

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for the legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the release of any information required to process insurance claims. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, including those not covered by my insurance carrier.

I understand and agree, regardless of my insurance status, I am ultimately responsible for the balance of my account. I have read all the information on both sides of this sheet and have completed all the information accurately to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ DATE: _____

PLEASE INDICATE (X) ANY OF THE FOLLOWING PROBLEMS:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Discomfort or clicking in the jaw | <input type="checkbox"/> Red, swollen or bleeding gums | <input type="checkbox"/> Blisters/sores in or around mouth | <input type="checkbox"/> Stained teeth |
| <input type="checkbox"/> Lost/broken fillings | <input type="checkbox"/> Teeth grinding/clenching | <input type="checkbox"/> Broken or chipped teeth | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Sensitivity when chewing | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sensitivity to hot | |

PREVIOUS DENTIST: _____ PHONE #: _____

LAST EXAM: _____ LAST X-RAYS: _____ HOW OFTEN DO YOU BRUSH: _____ FLOSS: _____

WHAT TYPE OF TOOTHBRUSH DO YOU USE? (CIRCLE) SOFT MED HARD

CHECK (X) IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV + | <input type="checkbox"/> GENERAL ALLERGIES | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> ALLERGIES TO DENTAL ANESTHETIC | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> RAPID WEIGHT GAIN/LOSS |
| <input type="checkbox"/> ANAPHYLAXIS | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> RADIATION TREATMENT |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> HEART PROBLEMS: DESCRIBE _____ | <input type="checkbox"/> RHEUMATIC-SCARLET FEVER |
| <input type="checkbox"/> ARTHRITIS/RHEUMATISM | | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> ARTIFICIAL JOINTS-HEART VALVES | <input type="checkbox"/> HEPATITIS-TYPE _____ | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ASTHMA/RESPIRATORY DISEASE | <input type="checkbox"/> HERPES/COLD OR CANKER SORES | <input type="checkbox"/> SKIN RASH |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> SNORING-SLEEP APNEA |
| <input type="checkbox"/> BLOOD DISEASES-HEMOPHILIA | <input type="checkbox"/> JAW PAIN | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> CANCER/CHEMOTHERAPY | <input type="checkbox"/> KIDNEY DISEASE OR MALFUNCTION | <input type="checkbox"/> SURGICAL IMPLANTS |
| <input type="checkbox"/> CHEMICAL/ALCOHOL DEPENDENCY | <input type="checkbox"/> LATEX ALLERGY | <input type="checkbox"/> THYROID (HYPER/HYPO) |
| <input type="checkbox"/> CORTISONE-STEROID TREATMENTS | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> TOBACCO HABIT |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> EPILEPSY-SEIZURE DISORDER | <input type="checkbox"/> NERVOUS PROBLEMS | <input type="checkbox"/> ULCERS/COLITIS |
| <input type="checkbox"/> FAINTING | <input type="checkbox"/> PACEMAKER/HEART SURGERY | <input type="checkbox"/> VENEREAL DISEASE |

DO YOU REQUIRE PREMEDICATION? _____

WHO IS YOUR MEDICAL DOCTOR? _____ PHONE #: _____

LIST ANY OTHER MEDICAL CONDITIONS/SURGERY? _____

DO YOU TAKE ANY MEDICATIONS? _____ PLEASE LIST: _____

DO YOU TAKE ANY VITAMINS or HERBAL SUPPLEMENTS? _____

LIST DRUG ALLERGIES, IF ANY: _____

HAVE YOU EVER TAKEN PHEN-FEN OR REDUX? _____

DO YOU SUFFER FROM DENTAL ANXIETY OR KNOWN BEHAVIOR ISSUES? _____ PLEASE LIST: _____

RATE YOUR GENERAL HEALTH 1 – 10 _____ ARE YOU HAPPY WITH YOUR SMILE? _____

ARE YOU TAKING BIRTH CONTROL? **Y/N** ARE YOU PREGNANT? **Y/N** HOW LONG? _____ ARE YOU NURSING? **Y/N**