Robert C Gittelman DDS PC

To help us better serve you, please fill out these forms for us. Thank you for your cooperation.

About You

Today's Date: _____

Name: _____ Preferred Name: _____

Birth Date: _____ SS #: _____ □ Male □ Female

Marital Status: □ Minor □ Single □ Married □ Other Guardian/Spouse's Name _____

Home Address: _____ Apartment # _____

City/State: _____ Zip: _____ County: _____

Employer: _____ Your Occupation: _____

Employer Address: _____ Suite: _____

City/State: _____ Zip: _____ County: _____

Are any family members' patients of Dr Gittelmans'? □ Yes □ No If yes, please list: _____

How did you hear about our office? □ Yellow Pages/Ad □Web □ Location

□ patient _____ □ insurance carrier: _____ □ other: _____

Contact Information

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Pager #: _____ Email: _____

In case of emergency who should be notified?

Name: _____ Relation: _____ Phone: _____

Responsible Party

Person Responsible for Account: _____ Relation to Patient: _____

Date of Birth: _____ S.S. #: _____ Driver License #: _____

Home Address: _____ Apartment #: _____

City/State: _____ Zip: _____ County: _____

Insurance Information

Dental Coverage □ Yes □ No - If no, skip to next section

Primary Insurance Company Name & Address: _____

_____

Insurance Phone #: _____ Group #: _____ ID# : _____

Insured's Name: _____ Insured's Date of Birth: _____ Relation to Patient: _____

Insured's SS#: _____ Insured's Employer: _____

Secondary Insurance Company Name & Address: _____

_____

Insurance Phone #: _____ Group #: _____ ID# : _____

Insured's Name: _____ Insured's Date of Birth: _____ Relation to Patient: _____

Insured's SS#: _____ Insured's Employer: _____

Medical and Dental History

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office – to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician.

ALL INFORATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & phone # of your physician's Name: _____
2. Date of Last Visit: _____Purpose of visit: _____
3. Do you suffer from any disability? _____ If yes, describe: _____
4. Have you ever, or do you now take illegal drugs? _____ If yes, what drugs, and when taken? _____

   Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.
5. Do you have AIDS, or are you HIV- positive? _____ If yes, current status: _____
6. Do you now have, or have you ever had a venereal disease? _____ If yes, describe: _____
7. Have you ever had, or do you now have hepatitis? _____ If yes, describe: _____
8. For females: Are you pregnant? _____ If yes, when are you due? _____
9. For females: Are you taking birth control pills? _____ ***Note: There are drugs & medication used in routine dental care that decreases the effectiveness of birth control pills.***
10. Have you had any serious illnesses or operations? _____If yes, describe: _____
11. Has a doctor told you that you need antibiotics to pre-medicate for dental work? _____
12. List all medications you are now taking or have taken previously on a regular basis, include over the counter medication and supplements. _____

    _____
13. Have you ever had an allergic reaction to medication? _____ If yes, describe: _____
14. List any known allergies:_____

    _____

Please check all of the following you have had or have currently:

□ Anemia	□ Cough up Blood	□ Cortisone Treatment	□ Scarlet Fever
□ Arthritis, Rheumatism	□ Depression	□ Rheumatic Fever	□ Glaucoma
□ Artificial Heart Valves	□ Cough, Persistent	□ Scarlet Fever	□ Sinus Trouble
□ Artificial Joints	□ Epilepsy	□ Shortness of Breath	□ Allergies
□ Asthma	□ Fainting	□ Skin Rash	□ Smoke tobacco
□ Back Problems	□ Glaucoma	□ Jaw Joint Pain	□ Smokeless tobacco
□ High Blood Pressure	□ Heart Murmur	□ Thyroid Problems	□ Blood Disease
□Kidney Disease	□ Ulcer	□ Diabetes	□ Mitral Valve Prolapse
□ Cancer	□ Liver Disease	□ Chemical Dependency	OTHER:
□ Codeine Allergy	□ Chemotherapy	□ Pacemaker	□ _____
□ Radiation	□ Circulatory Problems	□ Hay Fever	□ _____
□ Heart Disease	□ Hepatitis	□ Stroke	□ _____

Dental History

1. Previous Dentist: _____ Last dental visit? _____
2. Last Full Mouth X-rays? _____ Do you have any of your X-rays or dental records? _____
3. Are you in any type of dental pain? _____

In respect to any previous dental treatment have you:

4. Ever fainted? _____
5. Had allergic reaction? _____
6. Any other complications during following dental treatment? _____ If yes, describe _____

   _____
7. Do your gums bleed when brushing or eating? _____
8. Do you suffer from bad breath? _____
9. Are any of your teeth sensitive to heat, cold, or pressure? _____ When? _____
10. Do you grind your teeth or clench your jaw? _____ Do you wake up with soreness to your jaws? _____
11. Have you ever been told you have had gum disease or have any periodontal history? If so, describe: _____

    _____
12. Would you like your teeth to be whiter? _____
13. Do you have any other dental concerns or complaints? _____

To the best of my knowledge, the foregoing questions have been accurately answered.
"I understand that should there a change in my health during my dental treatment,
I am to inform the dentist at the earliest possible time."

Patient's Initials _____ Dentist's Initials _____

Authorization and Release

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the release of any information, including the diagnosis and records of treatment/examination rendered, to my insurance company and other healthcare providers as necessary. In our office, photographs may be taken of our patients for aid in determining proper diagnosis and to help visualize with the appropriate treatment options. I hereby authorize Robert C. Gittelman DDS PC to take photographs of my face, jaws, and teeth. I understand that the photographs will be used in a record of my care and may be used for educational purposes.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or asst in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

X_____ Date: _____ Relationship to Patient: _____
Signature of Patient, parent or guardian

X_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

X_____ Date: _____
Signature of Doctor

MEDICAL UPDATE *IF YES, HAVE PATIENT COMPLETE MEDICAL HISTORY UPDATE FORM.

DATE	INITIALS	CHANGE "YES"	"NO"