Bay Area Dental Office
Dr. William Merzo

WELCOME

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Patient Information

Name_____ Sex: Δ Male Δ Female
Last First Middle

Address_____ _____ City_____ State_____ Zip_____

Birth date _____ Soc.Sec. #_____ E-Mail Address: _____

Home Phone _____ Cell Phone _____ Status: Δ Single Δ Married Δ Child Δ Other

Do you have any Immediate Family who may be a patient at our office? Who? _____

Who may we notify in case of emergency _____ Phone _____

Who may we thank for referring you to our office?

Primary Insurance

Subscriber Name_____ Relationship to Patient Δ Self Δ Spouse Δ Child Δ Other
Last First

Subscriber Birth date _____ Subscriber Social Sec. # _____

Employed by _____ Occupation_____ Work Phone _____

Dental Insurance Company_____ Insurance Phone _____ Group # _____

Is patient covered by additional insurance? Δ Yes Δ No If yes, what is the insurance name?

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Δ Yes Δ No

If yes, describe _____ Are you currently under physician care? Δ Yes Δ No

Have you ever had a blood transfusion? Δ Yes Δ No Have you ever taken Fen-Phen/Redux Δ Yes Δ No

Women: Are you pregnant? Δ Yes Δ No Nursing? Δ Yes Δ No Taking birth control pills? Δ Yes Δ No

Please check (√) yes or no whether you have had any of the following:

ΔY ΔN AIDS/HIV Positive	ΔY ΔN Anaphylaxis	ΔY ΔN Anemia	ΔY ΔN Arthritis,Rheumatism
ΔY ΔN Artificial Joints	ΔY ΔN Asthma	ΔY ΔN Atopic (allergy prone)	ΔY ΔN Blood disease
ΔY ΔN Cancer	ΔY ΔN Chemical dependency	ΔY ΔN Chemotherapy	ΔY ΔN Epilepsy
ΔY ΔN Back problems	ΔY ΔN Cough, Persistent	ΔY ΔN Cough up blood	ΔY ΔN Diabetes
ΔY ΔN Liver Malfunction	ΔY ΔN Circulatory treatments	ΔY ΔN Fainting	ΔY ΔN Heart murmur
ΔY ΔN Jaw pain	ΔY ΔN Food allergies	ΔY ΔN Glaucoma	ΔY ΔN Headaches
ΔY ΔN High blood pressure	ΔY ΔN Nervous problems	ΔYΔN Pacemaker/Heart surgery	ΔY ΔN Psychiatric care
ΔY ΔN Radiation treatment	ΔY ΔN Cortisone treatments	ΔY ΔN Rapid weight gain or loss	ΔY ΔN Liver disease
ΔY ΔN Skin rash	ΔY ΔN Tuberculosis	ΔY ΔN Rheumatic/Scarlet fever	ΔY ΔN Shingles
ΔY ΔN Shortness of breath	ΔY ΔN Artificial heart valves	ΔY ΔN Mitral Valve Prolepses	ΔY ΔN Swelling of feet
ΔY ΔN Herpes	ΔY ΔN Pacemaker	ΔY ΔN Spinal Bifida	ΔY ΔN Hemophilia/Abnormal bleeding
ΔY ΔN Surgical implants	ΔY ΔN Respiratory disease	ΔY ΔN Hepatitis	ΔYΔN Allergic to Latex, Metal, chemical
ΔY ΔN Tobacco habit	ΔY ΔN Tonsillitis	ΔY ΔN Ulcer/Colitis	ΔY ΔN Kidney disease/malfunction
ΔY ΔN Heart problems, Describe:_____		ΔY ΔN Stroke	ΔY ΔN Thyroid disease or malfunction

Do you have any drug allergies? If yes, list all: _____

Are you currently taking any Medications? If yes, list all: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used for the dentist to help determine appropriate and healthful dental treatment. If there are any changes in my medical history, I will inform the dentist. I authorize the insurance company indicated on this form to pay the dentist 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.