Dr. Maria B. Mendrinos, D.D.S.
Dr. Stelianos Bredologos, D.D.S.

DATE:_____

PATIENT INFORMATION – PLEASE PRINT

NAME: LAST FIRST MIDDLE INITIAL

SEX Male / Female | Date of Birth / / | SSN - -

MAILING ADDRESS STREET/PO BOX | CITY | STATE | ZIP

CHILD ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCE ☐ WIDOWED ☐

HOME PHONE ( ) - | WORK PHONE ( ) - | CELL PHONE ( ) -

EMPLOYER/OCCUPATION | EMPLOYER ADDRESS

PARENT/SPOUSE/RESPONSIBLE PARTY NAME | Date of Birth / / | SSN - -

EMPLOYER NAME AND ADDRESS

PRIMARY CARE MEDICAL DOCTOR: | OFFICE PHONE( ) -

Emergency Contact Name_____Phone #_____

HOW DO YOU PREFER WE CONFIRM APPOINTMENTS?

☐ HOME ☐ WORK ☐ TEXT
☐ CELL ☐ E-MAIL
_____@_____

Do we have permission to leave a message at your home? Yes No
May we leave a message at your work? Yes No

HOW DID YOU HEAR ABOUT OUR OFFICE:

☐ FRIEND_____
☐ PHYSICIAN ETC_____
☐ INSURANCE
☐ PHONE BOOK Name:_____
☐ INTERNET: Search engine_____
☐ OTHER_____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE NAME	SECONDARY INSURANCE NAME
SUBSCRIBER: LAST FIRST	SUBSCRIBER: LAST FIRST
SSN - - / Date of Birth / /	SSN - - / Date of Birth / /
EMPLOYER / POLICY#	EMPLOYER / POLICY#
GROUP # / RELATIONSHIP	GROUP # / RELATIONSHIP

OFFICE POLICIES (Please Initial boxes below)

☐ You are responsible for the entire balance on your account at the time service is rendered unless we have a special contractual relationship with your insurance carrier. Please discuss this with us in advance to avoid misunderstandings.

☐ We expect full payment for co-payments and deductible at the time services are rendered.

☐ We cannot bill insurance for cosmetic or non-covered services. Full payment must be made at time of service.

☐ In the event that your balance is unpaid and your account is turned over to our collection agency there will be a mandatory collection fee of 30% of your unpaid balance.

☐ NOTICE: A fee of $35.00 will be charged for any missed appointment unless the office is notified of cancellation at least 24 hours in advance to the scheduled appointment time.

Your signature signifies an understanding of the above information and authorization for the Dentist to examine and treat you or your child as well as authorizes us to release dental information to your insurance company.

_____ _____

Signature of Patient/Parent DATE: Signature of Guardian (if not parent) DATE:

MEDICAL HISTORY

Have you ever had any of the following diseases or medical problems?

Y N	Abnormal Bleeding	Y N	Hepatitis	Y N	Frequent Headaches
Y N	Alcohol/Drug Abuse	Y N	Herpes/Fever Blisters	Y N	Sickle Cell Disease/Traits
Y N	Anemia	Y N	High Blood Pressure	Y N	Glaucoma
Y N	Arthritis	Y N	HIV+/AIDS	Y N	Sinus Problems
Y N	Artificial Bones/Joints/Valves	Y N	Hay Fever	Y N	Heart Attack
Y N	Asthma	Y N	Kidney Problems	Y N	Stroke
Y N	Blood Transfusion	Y N	Liver Disease	Y N	Thyroid Problems
Y N	Cancer/Chemotherapy	Y N	Low Blood Pressure	Y N	Heart Murmur
Y N	Colitis	Y N	Mitral Valve Prolapse	Y N	Tuberculosis
Y N	Congenital Heart Defect	Y N	Pacemaker	Y N	Heart Surgery
Y N	Diabetes	Y N	Psychiatric Problems	Y N	Ulcers
Y N	Difficulty Breathing	Y N	Radiation Treatment	Y N	Hemophilia
Y N	Emphysema	Y N	Rheumatic/Scarlet Fever	Y N	Venereal Disease
Y N	Epilepsy	Y N	Seizures	Y N	Shingles
Y N	Fainting Spells	Y N	Hospitalized for Any Reason		

Please list any Serious Medical Condition(s) that you have ever had:

_____
_____
_____

Medication Currently Taking:

_____
_____
_____

Are you allergic to any of the following drugs?

Y N	Penicillin	Y N	Dental Anesthetics
Y N	Aspirin	Y N	Codeine
Y N	Erythromycin	Y N	Latex
Y N	Tetracycline	Y N	Other

Please List any other drugs you are allergic to: _____

For Women:
Are you taking any birth control pill? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

Last dentist visit date:_____
Do you require antibiotics before treatment? ☐ Yes ☐ No Are you currently in pain? YES / NO
Have you ever had a serious/difficult problem associated with any previous dental work? YES / NO
Do you smoke or use tobacco in any other form? YES / NO

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical statues. I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment with my informed consent. I understand payment is due in full at the time of treatment unless prior arrangements have been approved.

_____

Signature Date

Our office is **HIPAA** Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.