PATIENT INFORMATION
(Please Print)

Date:_____Social Security #:_____Sex: ☐ M ☐ F Birthday:_____ Age: ____

Patient Name:_____
Last First Initial
Street Address:_____ City_____ State _____ _Zip_____

Home Phone:_____ Work Phone: _____Cell Phone:_____Email_____
Which number is best to reach you? Home ☐ Work ☐ Cell ☐

Your Employer's Name: _____Occupation: _____
Business Address: _____ Business Phone: _____

If you carry dental insurance, who is the subscriber? _____
Name of Dental Insurance Company: _____Group #: _____
In case of emergency, who should be notified? _____Phone: _____

Spouse's Name: _____Birth Date: _____SS#: _____
Spouse Employed By: _____Occupation: _____
Business Address: _____Business Phone:_____

Your Physician's Name: _____Phone #:_____
Have you ever had any of the following? (Check only boxes that apply)

☐ Heart Problems	☐ Hx of Cancer	☐ Arthritis
☐ Heart Murmur	☐ Radiation Treatment	☐ Sinus Problems
☐ Artificial Valve/Joints	☐ Hepatitis Type ____	☐ High/Low Blood Pressure
☐ Epilepsy/Seizures	☐ Kidney Disease	☐Allergies to Anesthetics
☐ Diabetes	☐ Smoking/Chewing Tobacco	☐ General Allergies
☐ Respiratory Disease	Chemical Dependency	☐ A.I.D.S./Immunosuppressive Disorder

Are you pregnant? _____ If so, how many weeks? _____
Do you have any drug allergies or have you ever had any adverse reaction to any medication ? _____
If yes, what? _____
Have you ever responded adversely to medical or dental treatment? _____
Are you under the care of a physician? No ☐ Yes ☐ If yes, for what treatment? _____
Are you taking any medication at this time? No ☐ Yes ☐ If yes, please list._____
Is there any other information we should know about your medical history? _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. David J. Gaz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Any cost incurred by this office during the collection process will be my responsibility. There is a $35.00 bank fee for a returned check. All appointments scheduled in the office and over the phone are considered confirmed appointments. We require a phone call by noon the day before the scheduled appointment so we may offer that time to another patient. Not notifying our office about your change in plans will result in additional charges. I have read the Notice of Privacy practices. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Signature Date Relationship