Welcome & Thank you for choosing Dr. Neil Carmony!

Our dental team strives to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we are happy to help.

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
SS# _____ E-mail Address _____ Cell # _____
If Student, Name of School/College _____ City _____ State _____
Patient or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
How did you hear about us? Phone Book _____ Internet _____ Friend _____
Person To Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Acct _____ Relationship to Pt _____
Address _____ Home Phone _____
E-mail _____ Cell Phone _____ Driver's License No. _____
Birthday _____ SS# _____ Work Phone _____
Is this Person Currently a Patient in our Office? ____ Yes ____ No ____ Wish to become patient

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is expected at the time of service.

____ Cash ____ Personal Check ____ I would like to Discuss the Office's Financial Options/Policies
Credit Card: ____ Visa ____ MasterCard ____ Am. Express ____ Discover

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____ Date Employed _____
Name of Employer _____ Work # _____ Ext. _____
Insurance Company _____ Group # _____ Policy/ID _____
Insurance Company Address _____ City _____ State _____ Zip _____
How much is your Deductible? _____ How much have you used? _____ Annual Max? _____
Do You Have Any Additional Dental Insurance Coverage? If Yes, Complete The Following:
Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____ Date Employed _____
Name of Employer _____ Work # _____ Ext. _____
Insurance Company _____ Group # _____ Policy/ID _____
Insurance Company Address _____ City _____ State _____ Zip _____
How much is your Deductible? _____ How much have you used? _____ Annual Max? _____

Authorization And Release

I certify that I have read and understand the information on both sides of this form to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize this office to leave voice messages regarding appointment times and other necessary information to the phone numbers I have disclosed. 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 my dental insurance 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.**

X _____ Date _____
(Signature of Patient or Parent/Guardian if minor.) ***Signature Required for Care.**

Patient Medical History

1. Have you been seen by a dentist in the last 12 months? _____Yes _____No
2. Are You Currently Under Medical Treatment? _____Yes _____No
3. Have You Ever Been Hospitalized For Any Surgical Operation Or Serious Illness? _____Yes _____No
4. Are You Currently Taking Any Medications (including non-prescription medicine)? _____Yes _____No
   If yes, please list medications you are taking _____
   _____
   Are you currently taking any medications for osteoporosis or chemotherapy, including
   ____ Zometa ____ Fosomax ____ Boniva ____ Reclast ____ Actonel ____ Aclasta ____ Xgeva
5. **Are You Allergic To Or Have You Had Any Reactions To The Following?**
   _____ Local Anesthetics _____ Aspirin _____ Penicillin
   (Lidocaine, Novocaine) _____ Erythromycin _____ Sulfa Drugs
   _____ Codeine _____ Other _____
6. Are You Pregnant Or Think You May Be Pregnant? _____Yes _____No
7. Are You Nursing? _____Yes _____No
8. **Do You Have Or Have You Had Any Of The Following?**
   _____ High Blood Pressure _____ Anemia _____ Asthma
   _____ Heart Trouble _____ Diabetes _____ Hepatitis
   _____ Fainting/Seizures _____ Excessive Bleeding _____ Allergies
   _____ Low Blood Pressure _____ Stroke _____ Heart Murmur
   _____ Sinus Problems _____ Tuberculosis _____ Rheumatic Fever
   _____ HIV Virus _____ Nervous Problems _____ Liver Disease
   _____ Cardiac Pacemaker _____ Other _____
   Have you had a Knee, Hip or any other joint replacement? _____Yes _____No

Patient Dental History

1. Do Your Gums Bleed While Brushing Or Flossing? _____Yes _____No
2. Are Your Teeth Sensitive To Hot Or Cold Liquids/Foods? _____Yes _____No
3. Are Your Teeth Sensitive To Sweet Or Sour Liquids/Foods? _____Yes _____No
4. Do You Feel Pain To Any Of Your Teeth? _____Yes _____No
5. Do You Have Any Sores Or Lumps In Or Near Your Mouth? _____Yes _____No
6. Have You Had Any Head, Neck, Or Jaw Injuries? _____Yes _____No
7. Have You Ever Experienced Any Of The Following Problems In Your Jaw?
   _____ Clicking
   _____ Pain (Joint, Ear, Side Of Face)?
   _____ Difficulty In Opening Or Closing?
   _____ Difficulty In Chewing?
   Have you had a hip, knee, or any other joint replacement? _____Yes _____No
8. Do You Have Frequent Headaches? _____Yes _____No
9. Do You Clench Or Grind Your Teeth? _____Yes _____No
10. Do Yo Bite Your Lips Or Cheeks Frequently? _____Yes _____No
11. Have You Ever Had Any Difficulty With Extractions In The Past _____Yes _____No
12. Have You Had Any Orthodontic Work? _____Yes _____No
13. Have You Ever Had Prolonged Bleeding Following Dental Work? _____Yes _____No
14. Have You Ever Had Instruction On The Correct Method Of Brushing Your Teeth? _____Yes _____No
15. Have You Ever Had Instruction On The Care Of Your Gums? _____Yes _____No
16. Do You Like Your Smile? _____Yes _____No

Is There Any Other Information About Your Health Which Should Be Known? _____
_____
_____
_____
_____
_____
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