Steven R. Salzman, D.D.S.
Family Dentistry

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Dear Patient:

Our office is most happy to complete and submit most insurance forms. We accept most preferred provider (PPOs) and standard insurance plans. Please keep in mind that most insurance companies do not cover all procedures at 100%. We encourage you to discuss any questions you may have regarding your specific plan with our staff, or to call the insurance company. Thank you for the opportunity to serve you.

Please read and sign below showing you understood the following:

- I understand that my insurance may/may not cover all dental services at 100%.
- My insurance plan may have a deductible and/or co-payment amount which is due at the time of service. I understand that I will be responsible for any further balance **not paid** by my insurance company.
- I accept full responsibility for all fees required for my child's dental care regardless of my marital status.
- I understand that there is a charge for failing an appointment or canceling without 24 hours notice.
- In the event that I/my family want to transfer to another office, I understand that my balance must be paid in full to receive copies of my dental records. There is a charge for duplication of dental records.
- I understand that if my check payment is returned as NSF from the bank there is a $20 NSF charge, which will be added to my account.
- I understand that I am responsible for any reasonable fees, expenses, or costs related to the collection of any unpaid balance, including commissions paid to attorneys or collection agencies.

_____

Patient/Parent Signature Date

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin	☐ Local Anesthetic
☐ Barbiturates (Sleeping pills)	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Iodine	☐ Other _____
☐ Latex	_____

DENTAL INFORMATION

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Chew on one side of mouth	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
		Clicking or popping jaw	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
		Dry mouth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
		Fingernail biting	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
		Food collection between the teeth	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
		Foreign objects	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
		Grinding teeth	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
		Gums swollen or tender	☐ Yes ☐ No	Sores or growths in your mouth	☐ Yes ☐ No
		Jaw pain or tiredness	☐ Yes ☐ No	How often do you floss? _____	
		Lip or cheek biting	☐ Yes ☐ No		
		Loose teeth or broken fillings	☐ Yes ☐ No	How often do you brush? _____	

How do you feel about your teeth?

Are you happy with the way they look?

Are your teeth comfortable?

If you could change anything in your mouth, what would it be?

Is there anything about your previous dental experience you would like to tell me?

Has treatment you have had done in the past been comfortable?

Do you feel the treatment you have had done in the past was worth worth your investment?

Person completing the form: Signature _____

Print Name: _____

If other than patient, indicate relationship: _____ Date_____