

Dr. Jeannie A. Molato and staff welcome you to our office!

PATIENT INFORMATION

DATE _____ SS#: _____

PATIENT NAME: _____
LAST NAME FIRST NAME MI

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SEX: M ____ F ____ AGE: _____ BIRTHDATE: _____

MARRIED: ____ SINGLE: ____ WIDOWED ____ SEPARATED ____ DIVORCED ____ MINOR ____

PHONE NUMBER CELL: _____ WORK: _____

HOME: _____ SPOUSE CELL: _____

PATIENT EMPLOYER OR SCHOOL: _____ EMAIL: _____

OCCUPATION: _____ OFFICE PHONE NO.: _____

SPOUSE'S NAME: _____
LAST NAME FIRST NAME MI

SPOUSE BIRTHDATE: _____ SPOUSE SS#: _____

SPOUSE EMPLOYER: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE ? : _____

DENTAL INSURANCE DO YOU HAVE DENTAL INSURANCE? : YES ____ NO ____

INSURED NAME: _____

RELATIONSHIP TO PATIENT: _____ INSURED BIRTHDATE: _____

INSURANCE COMPANY: _____ GROUP #: _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE?: YES ____ NO ____

SUBSCRIBER'S NAME: _____

BIRTHDATE: _____ SS#: _____

2ND INSURANCE COMPANY: _____ GROUP #: _____

ASSIGNMENT OF RELEASE

I CERTIFY THAT I, AND/OR MY DEPENDENT (S), HAVE INSURANCE COVERAGE WITH _____

INSURANCE COMPANY

AND ASSIGN DIRECTLY TO **DR. JEANNIE A. MOLATO AND ASSOCIATES** ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL THE CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. **DR. JEANNIE MOLATO AND ASSOCIATES** MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OF THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR UNTIL I DECIDE TO LEAVE THE PRACTICE AND SWITCH DENTISTS.

SIGNATURE OF PATIENT/PARENT

PRINT NAME OF PATIENT/PARENT

DATE

RELATIONSHIP TO PATIENT

EMERGENCY CONTACT: NAME _____ PHONE #: _____

RELATIONSHIP TO PATIENT: _____

DENTAL HISTORY

PATIENT NAME: _____

REASON FOR TODAY'S VISIT: _____

FORMER DENTIST: _____ CITY/STATE: _____

DATE OF LAST DENTAL VISIT: _____ DATE OF LAST DENTAL X-RAY: _____

PLEASE CIRCLE "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

BAD BREATH	YES/NO	JAW PAIN OR TIREDNESS	YES/NO
BLEEDING GUMS	YES/NO	LIP OR CHEEK BITING	YES/NO
BLISTERS ON THE LIPS OR MOUTH	YES/NO	LOOSE TEETH OR BROKEN FILLINGS	YES/NO
BURNING SENSATION ON TONGUE	YES/NO	MOUTH BREATHING	YES/NO
CHEW ON ONE SIDE OF THE MOUTH	YES/NO	MOUTH PAIN, BRUSHING	YES/NO
CIGARETTE, PIPE, OR CIGAR SMOKING	YES/NO	ORTHODONTIC TREATMENT	YES/NO
CLICKING OR POPPING JAW	YES/NO	PAIN AROUND THE 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

DO YOU HAVE ANY CONCERNS OF THE FOLLOWING:

SNORING YES/NO

SHAPE OR COLOR OF TEETH YES/NO

PLEASE ANY LET US KNOW IF YOU WOULD LIKE MORE INFORMATION ON ANY OTHER DENTAL CONCERNS.

HOW OFTEN DO YOU FLOSS? _____

HOW OFTEN DO YOU BRUSH? _____

HEALTH HISTORY

DR. JEANNIE MOLATO
LASER DENTAL
BAKERSFIELD

PATIENT NAME: _____

PHYSICIAN'S NAME: _____ DATE OF LAST VISIT: _____

HAVE YOU EVER USED A BIPHOSPHONATE MEDICATION? COMMON BRAND NAMES ARE FOSAMAX, ACETONEL, ATELVIA, DIDRONEL BONIVA? **YES/NO**

HAVE YOU EVER TAKEN ANY OF THE GROUP DRUGS COLLECTIVELY REFFERED TO AS "FEN-PHEN"? THESE INCLUDE COMBINATIONS OF LONIMIN, ADIPEX, FASTIN (BRAND NAMES OF PHENTERMINE). PONDIMIN (FENFLURAMINE) AND REDUX (DEXFENFLURAMINE). **YES/ NO**

PLEASE CIRCLE "YES" OR "NO" TO INDICATE IF YOU HAD ANY OF THE FOLLOWING:

AIDS/HIV	YES/NO	EPILEPSY	YES/NO	RADIATION TREATMENT	YES/NO
ANEMIA	YES/NO	FAINING OR DIZZINESS	YES/NO	RESPIRATORY DISEASE	YES/NO
ARTHRITIS, RHEUMATISM	YES/NO	GLAUCOMA	YES/NO	RHEUMATIC FEVER	YES/NO
ARTIFICIAL HEART VALVES	YES/NO	HEADACHES	YES/NO	SCARLET FEVER	YES/NO
ARTIFICIAL JOINTS	YES/NO	HEART MURMUR	YES/NO	SHORTNESS OF BREATH	YES/NO
ASTHMA	YES/NO	HEART PROBLEMS	YES/NO	SINUS TROUBLE	YES/NO
BACK PROBLEMS	YES/NO	HEPITIS TYPE ____	YES/NO	SKIN RASH	YES/NO
BLEEDING ABNORMAL, WITH EXTRACTIONS OR SURGERY	YES/NO	HERPES	YES/NO	SPECIAL DIET	YES/NO
BLOOD DISEASE	YES/NO	HIGH BLOOD PRESSURE	YES/NO	STROKE	YES/NO
CANCER	YES/NO	JAUNDICE	YES/NO	SWOLLEN FEET OR ANKLES	YES/NO
CHEMICAL DEPENDENCY	YES/NO	JAW PAIN	YES/NO	SWOLLEN NECK GLANDS	YES/NO
CHEMOTHERAPY	YES/NO	KIDNEY DISEASE	YES/NO	THYROID PROBLEMS	YES/NO
CIRCULATORY PROBLEMS	YES/NO	LIVER DISEASE	YES/NO	TONSILITIS	YES/NO
CONGENITAL HEART LESIONS	YES/NO	LOW BLOOD PRESSURE	YES/NO	TUBERCULOSIS	YES/NO
CORTISONE TREATMENTS	YES/NO	MITRAL VALVE PROLAPSE	YES/NO	TUMOR OR GROWTH ON HEAD/YES/NO OR NECK	
COUGH, PERSITENT OR BLOODY	YES/NO	NERVOUS PROBLEMS	YES/NO	ULCER	YES/NO
DIABETES	YES/NO	PACEMAKER	YES/NO	VENEREAL DISEASE	YES/NO
EMPHYSEMA	YES/NO	PSYCHIATRIC CARE	YES/NO	WEIGHT LOSS, UNEXPLAINED	YES/NO

WOMEN:

ARE YOU PREGNANT? **YES/NO** DUE DATE: _____ TAKING BIRTH CONTROL PILLS? **YES/NO** ARE YOU NURSING? **YES/NO**

MEDICATIONS:

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND THE CORRELATING DIAGNOSIS:

ARE YOU TAKING ANY BLOOD THINNERS (ASPIRIN, PLAVIX, COUMADIN, ETC.)? PLEASE LIST.

PHARMACY NAME: _____

PHONE (_____) _____

ALLERGIES:

- | | |
|--|----------------------------------|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> LATEX |
| <input type="checkbox"/> BARBITURATES (SLEEPING PILLS) | <input type="checkbox"/> IODINE |
| <input type="checkbox"/> LOCAL ANESTHESIA | <input type="checkbox"/> CODEINE |
| <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> SULFA |
| <input type="checkbox"/> OTHER: _____ | |
