DATE_____

Patient Information

_____ Mr./Mrs./Ms/Dr
(Last Name) (First Name) (Middle Name)

Nickname_____ Birth Date___/___/___ Gender M / F /Other

SS#_____

Address_____
(Street) (City) (State) (Zip code)

Employer_____Occupation_____

Home Phone ( ) _____ Work Phone ( ) _____

Cell ( ) _____Email_____

Spouse's Name_____ Employer/Occupation_____

Emergency Contact Name_____Phone #:_____

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in educational papers, displays or demonstrations.
I also authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered to my insurance company or companies.

_____
Signature

How did you hear about Dr. Pollack & who may we thank for referring you: _____

BILLING INFORMATION

PERSON RESPONSIBLE FOR PAYMENT:

_____ Mr./Mrs.//Ms/Dr
(Last Name) (First Name) (Middle Name)

Mailing Address

_____
(Street) (City) (State) (Zip)

Home Phone ( ) _____Work Phone ( ) _____ Cell ( ) _____Email_____

Employer_____ _____SS#_____ _____DOB_____

Dental Insurance Information

#1 Name of policy holder:_____SS#_____Birthdate_____Group#_____

Employer: _____ Subscriber/Member ID#_____

Insurance Co. #1_____
(Name) (Address) (Telephone#)

#2 Name of Policy holder_____SS#_____Birthdate_____Group#_____

Employer_____ Subscriber/Menber ID#_____

Insurance Co. # 2_____

What are your hobbies or special interests? (For example, sports, self-improvement, education)

_____

Do you or have you had any of the following:

AIDS or HIV infection Y/N
Anemia Y/N
Arthritis Y/N
Asthma Y/N
Blood transfusion. If yes, date: _____ Y/N
Cancer/Chemotherapy/Radiation Treatment Y/N
Cardiovascular disease: If yes, specify below:
____Artificial heart valves ____High blood pressure
____Heart Attack ____Low blood pressure
____Heart Murmur ____Mitral valve prolapse
____Stent ____Pacemaker
Diabetes: If yes, specify below: Y/N
____Type I (insulin dependent) ____Type II
Epilepsy Y/N
Excessive/Abnormal bleeding Y/N
Fainting spells or seizures Y/N

Are you or could you be pregnant? Y/N ___ Months___

Nursing? Y/N

Gastrointestinal/Digestive Problems Y/N
If yes, specify: _____
Glaucoma Y/N
Hepatitis, Jaundice or liver disease Y/N
Joint replacement: If yes, when Y/N
_____
Kidney problems Y/N
Nervous Disorder Y/N
Severe headaches/migraines Y/N
Sinus trouble/Allergies Y/N
Sleep disorder Y/N
Sores or ulcers in the mouth Y/N
Stroke Y/N
Tuberculosis Y/N
Thyroid problems Y/N
Osteoporosis Y/N
* COVID-19 Y/N
Other_____

Other_____

Have you seen your physician or been hospitalized in the last two years?

If yes, please explain (list all surgical procedures & dates in your lifetime) _____

Physician's Name, Address & Phone _____

Do you smoke? Y/N If yes, how much and how often: _____

Do you drink alcohol? Y/N If yes, how much and how often: _____

*Do you have any instructions from a physician to take antibiotics for dental work? Y/N If yes, what? _____

Have you had unfavorable reactions &/or are you allergic to any of the following (please circle)

Aspirin Codeine Anesthetics Novocaine Sedatives
Latex Sulfa Penicillin/Antibiotics Other Drugs (list) _____

_____

Please list all drugs currently being taken:

_____

_____

The information above is correct to the best of my knowledge. I give my consent to have the treatment recommended for my benefit (or for my minor child) only after it has been mutually approved.

_____ Date_____
(Signature)

_____ Date_____
(Signature)

(5/20/2020)