

GARY R. ZEIDLER, D.D.S. CLAYTON G. ZEIDLER, D.D.S.

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We are complimented that you have selected us to provide dental care for you and your family.  
Whom may we thank for referring you to our office? \_\_\_\_\_

**Patient Information**

Date \_\_\_\_\_ Patient's Name \_\_\_\_\_  
Last First Middle  
Address \_\_\_\_\_  
Street City State Zip  
Home Ph # ( ) \_\_\_\_\_ Work Ph # ( ) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Drivers Lic # \_\_\_\_\_  
Cell Ph # ( ) \_\_\_\_\_ Email Address \_\_\_\_\_  
Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ If patient is a minor, give parent's/guardian's name \_\_\_\_\_  
If patient is a full-time student fill in school name \_\_\_\_\_ City \_\_\_\_\_  
Name of nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_ Ph. # \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Ph # ( ) \_\_\_\_\_

**Responsible Party Information**

Patient's Name \_\_\_\_\_  
Last First Middle Marital Status  
Address \_\_\_\_\_  
Street City State Zip  
How long at this address \_\_\_\_\_ Home Ph # ( ) \_\_\_\_\_ Work Ph # ( ) \_\_\_\_\_  
Previous address (if less than 3 5 years) \_\_\_\_\_  
Street City State Zip  
Social Security Number \_\_\_\_\_ Birth date \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. of years employed \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. of years employed \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Birth date \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

**Insurance Information**

Insured's Name \_\_\_\_\_ Insured's Soc. Sec # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_  
Is policy connected with your union ? Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Union \_\_\_\_\_ Local No. \_\_\_\_\_  
Do you have dual coverage ? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes; Please complete the following secondary insurance information.  
Insured's Name \_\_\_\_\_ Insured's Soc. Sec # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

**Dental Information**

Do your gums bleed when you brush ? Yes \_\_\_ No \_\_\_  
Are your teeth sensitive to heat or cold ? Yes \_\_\_ No \_\_\_ Pressure Yes \_\_\_ No \_\_\_ Sweets Yes \_\_\_ No \_\_\_  
Do you grind or clench your teeth ? Yes \_\_\_ No \_\_\_  
Do you have any fear of dental work ? Yes \_\_\_ No \_\_\_  
Date of Last dental examination \_\_\_\_\_ What was done at the time ? \_\_\_\_\_  
Former Dentist Name \_\_\_\_\_ City \_\_\_\_\_  
How would you describe your current dental problem? \_\_\_\_\_  
How do you feel about the appearance of your teeth? \_\_\_\_\_

## Medical Information

1. Are You having pain or discomfort at this time ? .....YES NO
2. Have you been a patient in the hospital during the past two years ? .....YES NO
3. Are You now taking any medication or drugs .....YES NO  
If yes, please list: \_\_\_\_\_
4. Have you taken any medication or drugs during the past two years including appetite suppressants - fen phen (fenfluramine & phentermine) or dexfenfloramine or fenfluramine?.....YES NO
5. Have you been under the care of a medical doctor during the past two years or since taking any of the appetite suppressants named above? YES NO

Physician's Name \_\_\_\_\_ Phone No ( ) \_\_\_\_\_

Address \_\_\_\_\_

6. Are you sensitive or allergic to any medication or anesthetics?  
If yes, please list: \_\_\_\_\_
7. Indicate which of the following you have had or have present. Circle "YES" or "NO" to each item.

Do you smoke? .....YES NO	Sickle Cell Disease .....YES NO	Allergy to latex .....YES NO
Heart Failure .....YES NO	Artificial joints (hip, knee, etc.) .....YES NO	Allergy to metal (jewelry, etc.) .....YES NO
Heart Disease or Attack .....YES NO	Kidney Trouble .....YES NO	Hepatitis B Serum .....YES NO
Angina Pectoris .....YES NO	Ulcers .....YES NO	Venereal Disease .....YES NO
Congenital heart Disease .....YES NO	Diabetes .....YES NO	A.I.D.S. ....YES NO
Heart Murmur .....YES NO	Thyroid Problems .....YES NO	H.I.V. Positive .....YES NO
High Blood Pressure .....YES NO	Glaucoma .....YES NO	Cold Sores/Fever Blisters .....YES NO
Arteriosclerosis .....YES NO	Cancer .....YES NO	Blood Transfusion .....YES NO
Mitral Valve Prolapse .....YES NO	Emphysema .....YES NO	Hemophilia .....YES NO
Artificial Heart Valve .....YES NO	Chronic Cough .....YES NO	Anemia .....YES NO
Heart Pacemaker .....YES NO	Tuberculosis .....YES NO	Bruise Easily .....YES NO
Heart Surgery .....YES NO	Asthma .....YES NO	Liver Disease .....YES NO
Rheumatic Fever .....YES NO	Hay Fever .....YES NO	Yellow Jaundice .....YES NO
Arthritis .....YES NO	Allergies or Hives .....YES NO	Epilepsy or Seizures .....YES NO
Rheumatism .....YES NO	Sinus Trouble .....YES NO	Fainting or Dizzy Spells .....YES NO
Cortisone Medicine .....YES NO	Radiation Therapy .....YES NO	Nervousness .....YES NO
Drug Addiction .....YES NO	Chemotherapy .....YES NO	Tumors .....YES NO
Stroke .....YES NO	Hepatitis A (infectious) .....YES NO	Developmentally Disabled .....YES NO
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? .....YES NO
9. Do you ever wake up from sleep and feel short of breath? .....YES NO
10. Are you on a special diet? .....YES NO
11. Do you have or have you had any disease, condition or problem not listed above ? .....YES NO

If yes Please list: \_\_\_\_\_

**FOR WOMEN ONLY:**

Are you pregnant ?  Yes, what month? \_\_\_\_\_ Are you nursing?  Yes  No Are you taking birth control pills?  Yes  No

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT:**

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aide deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection, with (name of patient) \_\_\_\_\_  
I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility of payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon date, I understand that a 1 -1/2% finance charge (18% APR) may be added to my account in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

FOR OFFICE USE: Reviewed by Dr. \_\_\_\_\_ Date \_\_\_\_\_