WELCOME TO OUR OFFICE

Steven H. Goldstein, DDS, PC

Date _____ Who may we thank for referring you? _____

Patient's Name _____ Preferred Name _____ Sex ___ Age ____ Date of Birth _____

Primary Address _____ City _____ State ____ Zip _____

Secondary Address _____ City _____ State ____ Zip _____

Preferred number to be contacted (____) _____ E-mail _____

Marital Status _____ Spouse/Partner Name _____

Person Financially Responsible For This Account _____

Billing Address _____ City _____ State ____ Zip _____

FEE FOR SERVICE DECLARATION

This office is fee for service and is NOT contracted with any insurance company. All payment is due at time of service. As a courtesy, a claim can be filed with your insurance provider when the office is provided the insurance information. The office is not responsible for any claim not covered for services rendered.

Understand Initials _____

Name of Carrier _____ Policy Holder _____ Date of Birth _____

Employer _____ Group # _____ SS # or ID # _____

Claims Address _____ Phone (____) _____

Insurance Card Present? _____

_____ Signature of Patient

_____ Signature of Responsible Party

FOR MINOR CHILDREN Name of Parent or Gaurdian _____ Childs Age _____

Have you been seen in a dental office within the last year? _____

Are there x-rays that were taken with in the last year that we can request from this office? _____

Office Name _____ Phone (____) _____

PLEASE FILL OUT THE QUESTIONNAIRE BELOW

What is the reason for your visit today? _____

Are you experiencing dental related pain? _____ Do you have an allergy to Latex material in your mouth? _____

Have you been instructed by your medical doctor that you need to premedicate for dental procedures? _____

Is there any reason you can NOT have local anesthetic? ❑ Yes ❑ No Reason _____

For Women: Are you pregnant? ❑ Yes ❑ No If Yes, what month? _____

Preferred Pharmacy _____ Cross Streets _____ Phone (____) _____

10752 N 89th Place, Suite 217 | Scottsdale, AZ 85260 | (480) 614-1597 | info@stevenhgoldsteindds.com | www.stevenhgoldsteindds.com

Please list ALL medications you are taking below

Please list any Medication allergies below

Please list any supplements you are taking below

Do you have, or have you ever had any of the following:

	YES	NO
AIDS	❑	❑
HIV	❑	❑
Hepatitis A, B, and/or C ____	❑	❑
HPV	❑	❑
Herpes Simplex II	❑	❑
Tuberculosis	❑	❑
COPD	❑	❑
Asthma with inhaler	❑	❑
Joint Replacement	❑	❑
Right/left: Knee, Hip, Shoulder, other _____		
Pre-medicate	❑	❑
Blood Thinners	❑	❑
Kidney Transplant	❑	❑
Heart Attack (Within the last 6 months)	❑	❑
Heart Valve	❑	❑
Repair or Replacement (please circle)		

	YES	NO
Heart Bypass Surgery	❑	❑
Heart Disease	❑	❑
Congestive Heart Failure, Cardiac Myopathy (please circle)		
Mitral Valve Prolapse	❑	❑
Pacemaker	❑	❑
Defibulator Implant	❑	❑
Aneurism	❑	❑
Epilepsy	❑	❑
High Blood Pressure	❑	❑
Diabetes Type I or II (please circle)	❑	❑
Hypoglycemia	❑	❑
Thyroid, High or Low (please circle)	❑	❑
Auto Immune, Type _____	❑	❑
Blackouts/Fainting	❑	❑

	YES	NO
Excessive Bleeding	❑	❑
Cancer	❑	❑
Type _____		
Currently in Treatment? _____		
Head Injury	❑	❑
Stroke	❑	❑
Seizures, from? _____	❑	❑
Kidney Problems ie: stones	❑	❑
GERDs/Acid Reflux	❑	❑
Hearing Problems	❑	❑
Glaucoma	❑	❑
Facial Injuries	❑	❑
Tobacco product use?	❑	❑
Type _____		
Substance Abuse	❑	❑
Type _____		
Dry Mouth	❑	❑
Related to: Medication, Chemotherapy, Radiation, Vitamin Deficiencies (please circle)		