Brian N. Hollander, D.D.S., M.S. *DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY*

Date ____________________ (PLEASE PRINT) Home Phone ____________________

Patient ____
Last Name First Name Initial Preferred Name

Spouse/Parent or Guardian, if minor ____

Home Address ____________________ City ____________________ State ______ Zip ______

Sex: ☐ M ☐ F Age ____ Birthdate ________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by ____________________ Occupation ____________________

Business Address ____________________ Business Phone ____________________

Social Security # ____________________ Driver's License # ____________________

Spouse's Name ____

Spouse Employed by ____________________ Occupation ____________________

Spouse's Business Address ____________________ Business Phone ____________________

Spouse's Social Security # ____________________ Spouse's Date of Birth ____________________

Who is responsible for this account? ____________________ Relationship to Patient ____________________

Name of Dental Insurance Company ____________________ Group Number ____________________

Mailing address ____________________ Telephone # ____________________

Who is Insured? ☐ Patient ☐ Spouse Insured's Date of Birth ____________________

If you have second insurance carrier, Name of Insurance Company ____________________ Group Number ____________

In case of emergency, who should be notified? ____________________ Phone ____________

Whom may we thank for referring you? ____

OFFICE POLICIES AND PROCEDURES

Insurance deductible amounts are collected before services begin. Your copayment will be estimated and is due and collected on the day of service. If there is an overpayment, it will be refunded to you.

Rejection or Reduction of Your Claim: Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claim. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanations should be made to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. Any balance due on your account must be paid within 60 days of date of service to avoid a finance charge of 18%.

Our office reserves the right, at our discretion, to charge for missed or broken appointments. We request that you give us 48 hour notice if it becomes necessary for you to reschedule your visit.

Signature ________________________________ Date ____________________

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? .... Yes No
   If yes, for what? ____________
   Physician's Name ____________ Phone ____________
   Address ____________ City ____________ State ______ Zip ______
2. Have you taken any medication or drugs during the past two years? .... Yes No
3. Are you taking any medication, drugs or pills now? .... Yes No
   If yes, please list: ____________
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? .... Yes No
   If yes, please list: ____________
5. Have you been a patient in the hospital during the past five years? .... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" for each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Liver Disease	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Hepatitis A, B, or C	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	Venereal Disease	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	A.I.D.S.	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	H.I.V. Positive	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Cold Sores/Fever Blisters	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Blood Transfusion	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Hemophilia	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Sickle Cell Disease	Yes	No
Arthritis/Rheumatism	Yes	No	Smoking or Tobacco	Yes	No	Bruise Easily or Abnormal Bleeding	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No			

7. Alcohol or Drug Addiction? .... Yes No
8. Have you ever taken Fen-phen or Pondimin? .... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? .... Yes No
   If yes, please list: ____________
10. **Women**, are you: **Pregnant?** Yes, ___Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature ____________ Date ____________