Dr. Jessica Nieva D.D.S.,P.C.

fentonfamilydentistry

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date: _____

Patient Information:

Name_____ Birth Date_____/_____/_____ Social Security #_____-_____-_____
Address_____City/State/Zip_____
Home Phone(_____)_____Work Phone(_____)_____ext._____ Cell(_____)_____

Sex: *Male* *Female* (Circle One) Marital Status: *Married* *Single* *Divorced* *Widowed* *Partnered* (Circle One)
Email: _____ Would you like to receive correspondence via email? ( ) *YES* ( ) *NO*

Student Status: ( ) Full Time ( ) Part Time Name of School: _____
Whom may we thank for referring you to our office? _____

Responsible Party:

Person Responsible for Account_____ *Relation to patient:* *Self* *Spouse* *Parent* *Other*
Birth date_____/_____/_____Social Security # _____-_____-_____ Date Employed_____
Address_____City/State/Zip_____
Home Phone (____) _____Work Phone (____) _____ ext._____ Cell (____) _____
Email: _____ Drivers License#_____

Primary Insurance Information:

Name of Insured: _____ Relation to patient: *Self* *Spouse* *Parent* *Other*
Insured SS #_____-_____-_____ Insured Birth date_____/_____/_____
Employer: _____ Insurance Company: _____
Employer Address: _____ Insurance Address: _____
City/State/Zip: _____ City/State/Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Relation to patient: *Self* *Spouse* *Parent* *Other*
Insured SS #_____-_____-_____ Insured Birth date_____/_____/_____
Employer: _____ Insurance Company: _____
Employer Address: _____ Insurance Address: _____
City/State/Zip: _____ City/State/Zip: _____

Dental History:

Reason for today's visit: _____ Date of last dental visit: _____
Former Dentist: _____ Date of last dental x-rays:_____

Circle if you have had problems with any of the following:

Bad Breath
Bleeding Gums
Clicking or popping jaw
Food collection between teeth
Sensitivity to hot
Sensitivity to sweets
Sores or growths in your mouth
Grinding Teeth
Sensitivity to cold
Sensitivity when biting
Periodontal treatment
Loose teeth or broken fillings

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ( ) Yes ( ) NO If yes, please explain_____
Have you ever been hospitalized or had a major operation? ( ) Yes ( ) NO If yes, please explain_____
Have you ever had a serious head or neck injury? ( ) Yes ( ) NO If yes, please explain_____
Are you taking any medications, pills, or drugs? ( ) Yes ( ) NO If yes, please explain_____
Do you take, or have you taken, Phen-Fen or Redux? ( ) Yes ( ) NO _____
Are you on a special diet? ( ) Yes ( ) NO
Do you use tobacco? ( ) Yes ( ) NO
Do you use controlled substances? ( ) Yes ( ) NO

Women: Are you:
Pregnant/Trying to get pregnant? ( ) Yes ( ) NO Taking oral contraceptives? ( ) Yes ( ) NO Nursing? ( ) Yes ( ) NO

Are you allergic to any of the following?
( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex ( ) Local Anesthetics
( ) Other If yes, please explain: _____

Do you have, or have you had, any of the following?

PLEASE BE SURE TO CHECK YES OR NO

Acid Reflux	( )Yes ( )No	Congenital Heart Disorders	( )Yes ( )No	Hepatitis A	( )Yes ( )No	Renal Dialysis	( )Yes ( )No
AIDS/HIV	( )Yes ( )No	Cortisone Medicine	( )Yes ( )No	Hepatitis B	( )Yes ( )No	Rheumatic Fever	( )Yes ( )No
Alzheimer's Disease	( )Yes ( )No	Diabetes	( )Yes ( )No	Hepatitis C	( )Yes ( )No	Rheumatism	( )Yes ( )No
Anaphylaxis	( )Yes ( )No	Drug Addiction	( )Yes ( )No	High Blood Pressure	( )Yes ( )No	Scarlet Fever	( )Yes ( )No
Anemia	( )Yes ( )No	Easily Winded	( )Yes ( )No	High Cholesterol	( )Yes ( )No	Shingles	( )Yes ( )No
Angina	( )Yes ( )No	Emphysema	( )Yes ( )No	Hives/ Rash	( )Yes ( )No	Sickle Cell Disease	( )Yes ( )No
Anxiety	( )Yes ( )No	Epilepsy or Seizures	( )Yes ( )No	Hypolglycemia	( )Yes ( )No	Sinus Trouble	( )Yes ( )No
Arrhythmia	( )Yes ( )No	Excessive Bleeding	( )Yes ( )No	Irregular Heartbeat	( )Yes ( )No	Spina Bifida	( )Yes ( )No
Arthritis/Gout	( )Yes ( )No	Excessive Thirst	( )Yes ( )No	Kidney Problems	( )Yes ( )No	Stomach/Intestinal Disease	( )Yes ( )No
Artificial Joint	( )Yes ( )No	Fainting/Dizziness	( )Yes ( )No	Leukemia	( )Yes ( )No	Stroke	( )Yes ( )No
Artificial Heart Valve	( )Yes ( )No	Frequent Cough	( )Yes ( )No	Liver Disease	( )Yes ( )No	Swelling Of Limbs	( )Yes ( )No
Asthma	( )Yes ( )No	Frequent Diarrhea	( )Yes ( )No	Low Blood Pressure	( )Yes ( )No	Thyroid Disease	( )Yes ( )No
Blood Disease	( )Yes ( )No	Frequent Headaches	( )Yes ( )No	Lung Disease	( )Yes ( )No	Tonsillitis	( )Yes ( )No
Blood Transfusion	( )Yes ( )No	Glaucoma	( )Yes ( )No	Mitral Valve Prolapse	( )Yes ( )No	Tuberculosis	( )Yes ( )No
Bruise Easily	( )Yes ( )No	Hay Fever	( )Yes ( )No	Pain in Jaw Joints	( )Yes ( )No	Tumors or Growths	( )Yes ( )No
Cancer	( )Yes ( )No	Heart Attack/Failure	( )Yes ( )No	Parathyroid Disease	( )Yes ( )No	Ulcers	( )Yes ( )No
Chemotherapy	( )Yes ( )No	Heart Murmur	( )Yes ( )No	Psychiatric Care	( )Yes ( )No	Venereal Disease	( )Yes ( )No
Chest Pains	( )Yes ( )No	Heart Pace Maker	( )Yes ( )No	Radiation Treatment	( )Yes ( )No	Yellow Jaundice	( )Yes ( )No
Cold Sores/Fever Blisters	( )Yes ( )No	Hemophilia	( )Yes ( )No	Recent Weight Loss	( )Yes ( )No		

Have you ever had any serious illness not listed above? ( )Yes ( )No If yes, please explain: _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and /or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company (iss)
Dr. Jessica Nieva all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Jessica Nieva 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 or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

***In the event you are unable to keep your appointment, kindly give us a 24 hour notice to avoid a $50.00 missed/cancelled appointment fee.**

Signature of Patient, Parent, Guardian _____ Date _____

Print Name of Patient, Parent, Guardian _____ Relationship to Patient_____