

ROBERT M. SOLOW, DDS., INC.

PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME: _____ (FIRST) _____ (LAST) _____ (MI) _____ (Preferred name)

GENDER: Male Female STATUS: single married child other
If Married, Spouse's Name: _____

DATE OF BIRTH: ____/____/____ Age: ____ SS#: ____--____--____
month day year Driver's License #: _____

HOME ADDRESS: _____ APT. #: _____
CITY: _____ STATE: _____ ZIP: _____

HOME #: () WORK #: () Ext.

CELL #: () E-MAIL ADDRESS: _____

We provide all our patients with e-mail and text message appointment reminders. If you wish NOT to receive any of these services please check the box/s below (your e-mail address as well as other personal information is for office use only and will not be shared or sold to advertisers.):

- Please DO NOT text message me. Please DO NOT e-mail me.

EMPLOYER: _____ How long have you been employed with this company? _____

EMPLOYER'S ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ OCCUPATION: _____

HOW DID YOU LEARN ABOUT OUR DENTAL OFFICE? (Please check one of the boxes below)

- Internet Driving by Phone Book Word of mouth
 Friend (Name: _____) Relative: (Name: _____, relation: _____)

EMERGENCY CONTACT

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

HOME #: () WORK #: () Ext.

CELL #: () OTHER #: ()

YOUR MEDICAL DOCTOR: _____ DOCTOR'S PHONE #: ()

6024 Fallbrook Avenue, Suite 101
Woodland Hills, California 91367
818-999-0104

ROBERT M. SOLOW, DDS., INC.

(If you do not have dental insurance coverage, please skip to next section, pg. 3)

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

COMPANY NAME: _____ PHONE #: (____) _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURED'S SS#: _____ -- _____ -- _____ GROUP # (Plan, Local or Policy#): _____

INSURED'S NAME: _____ RELATIONSHIP: _____ D.O.B: ___/___/___

INSURED'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

COMPANY NAME: _____ PHONE #: (____) _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURED'S SS#: _____ -- _____ -- _____ GROUP # (Plan, Local or Policy#): _____

INSURED'S NAME: _____ RELATIONSHIP: _____ D.O.B: ___/___/___

INSURED'S EMPLOYER: _____

ROBERT M. SOLOW, D.D.S, INC. – DENTAL INSURANCE POLICES

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided
I certify that I or my child is covered by insurance and assign directly to Dr. Robert M. Solow 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 hereby authorize the dentist to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Patient Signature: _____

Date: _____

(Signature of legal Guardian or Parent if Patient is under 18 years of age)

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www.robertsolowdds.com

ROBERT M. SOLOW, DDS., INC.

SYMPTOMS Have you experienced any of the following in the last 3 months? (Please circle Yes or No for each)

- Yes / No Chest pain (angina)
Yes / No Fainting spells
Yes / No Unexplained weight loss
Yes / No Fever
Yes / No Night sweats
Yes / No Persistent cough
Yes / No Coughing up blood
Yes / No Shortness of Breath
Yes / No Diarrhea
Yes / No constipation
Yes / No Frequent urination
Yes / No Ringing in ears
Yes / No Headaches
Yes / No Dizziness
Yes / No Bruise easily
Yes / No Frequent vomiting
Yes / No Jaundice
Yes / No Dry mouth
Yes / No Excessive thirst
Yes / No Difficulty swallowing
Yes / No Swollen neck glands
Yes / No Swollen ankles
Yes / No Joint pain, stiffness
Yes / No Sinus problems

CONDITIONS Have you had or do you have any of the following? (Please circle Yes or No for each)

- Yes / No Artificial joints (Type Year)
Yes / No Heart disease
Yes / No Family history of heart disease
Yes / No Heart attack
Yes / No Heart defects
Yes / No Heart murmurs
Yes / No Pacemaker
Yes / No Artificial heart valve
Yes / No Hardening of arteries
Yes / No High blood pressure
Yes / No Low blood pressure
Yes / No Stroke
Yes / No Rheumatic fever
Yes / No Seizures
Yes / No Cosmetic surgery
Yes / No Surgeries
Yes / No Ulcers
Yes / No Diabetes
Yes / No Family history of diabetes
Yes / No Tumors
Yes / No Cancer
Yes / No Chemotherapy
Yes / No Radiation
Yes / No Arthritis, rheumatism
Yes / No Emphysema or other lung disease
Yes / No Asthma
Yes / No Tuberculosis
Yes / No Kidney or bladder disease
Yes / No Eating disorders
Yes / No Osteoporosis
Yes / No Thyroid disease
Yes / No Hepatitis (Type)
Yes / No Sexual transmitted disease
Yes / No Herpes
Yes / No Canker or cold sores
Yes / No Anemia
Yes / No Liver disease
Yes / No Glaucoma
Yes / No Transplant

CONDITIONS CONTINUED... This information will not be released unless specifically authorized by patient. (Please circle Yes or No for each)

- Yes / No HIV
Yes / No Anxiety
Yes / No Treatments for emotional condition
Yes / No Depression

ALLERGIES Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

- Yes / No Aspirin
Yes / No Darvon
Yes / No Valium
Yes / No Demerol
Yes / No Codeine
Yes / No Vicodin
Yes / No Percodan
Yes / No Penicillin
Yes / No Amoxicillin
Yes / No Sulfa
Yes / No Erythromycin
Yes / No Tetracycline
Yes / No Food (type)
Yes / No Nitrous Oxide
Yes / No Metal
Yes / No Novocain or Xylocaine
Yes / No Latex
Yes / No Iodine
Yes / No Acrylic

Please list any other medications or substances you are or may be allergic to: _____

MEDICATIONS / SUBSTANCES Are you taking or have you taken any of the following in the last 3 months? (Please circle Yes or No for each)

- | | | |
|-------------------------------------|------------------------------------|------------------------------|
| Yes / No Antibiotics | Yes / No Supplements | Yes / No Recreational drugs |
| Yes / No Over-the-counter medicines | Yes / No Aspirin Daily | Yes / No Tobacco in any form |
| Yes / No Weight loss medications | Yes / No Blood Thinners (Coumadin) | Yes / No Alcohol |
| Yes / No Corticosteroids | Yes / No Bisphosphonate (Fosamax) | |

Please list all medications you are currently taking: _____

WOMEN ONLY (Please circle Yes or No for each)

- Yes / No Are you taking birth control pills?
 Yes / No Are you or could you be pregnant? If YES, what month? _____
 Yes / No Are you nursing?

ALL PATIENTS (Please circle Yes or No for each)

- Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
 If YES, explain: _____
- Yes / No Have you ever been pre-medicated for dental treatment?
 If YES, why: _____
- Yes / No Have you ever taken Pondimin or Fen-Phen? If YES, when: _____
- Yes / No Are you a smoker? If YES, how much do you smoke per day? _____ How long have you smoked? _____

The practice of dentistry involves treating the whole person. If Dr. Solow determines that there may be a medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

Do you authorize Dr. Solow and/or his staff to contact your physician if necessary? YES NO

Physician's Name: _____ Office phone #: _____

ROBERT M. SOLOW, D.D.S, INC. – DENTAL PRACTICE POLICES

- We invite you to discuss with us any questions regarding our services. We are best able to address your dental needs, desires and concerns when there are open communications to assure mutual understanding between you and our staff.
- The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my or my child’s medical status. I authorize the dental staff to perform necessary dental services for me/ my minor/child.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our business manager. In the absence of a preexisting financial arrangement, if your account is greater than 90 days past due, you may be held liable for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your account.
- In an effort to improve patient scheduling and care, we respectfully request that you advise us of your need to cancel or change your appointment at least **24 hours** prior to your reserved time. Please extend this courtesy both to us and to other patients who may benefit from your appointment time. If you find it necessary to change or cancel an appointment at the last minute, there will be a charge of **\$45.00** for each hour of appointed time. While we understand that unforeseen emergencies and illness may occur, we ask that you consider the value of our time and the needs of other patients.
- I certify that I have read and understand the above statements of Office Policy and Health History which I completed. I have answered each question accurately and to the best of my knowledge. I will continue to inform this office and staff of any change in my health status and/or medication. I also consent to Dr. Solow’s office using my cell phone to contact me regarding any appointments, insurance information or account matters. Further, I will not hold Dr. Solow, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____
(Signature of legal Guardian or Parent if Patient is under 18 years of age)

Date: _____

MEDICAL UPDATES (Office use only)

<u>Date</u>	<u>Changes to Health History</u>	<u>Dentist or Hygienist Initials</u>