



C & E Elite Family Dentistry, SC

"EXPERTS IN CREATING HEALTHY ATTRACTIVE SMILES"

7155 N. PORT WASHINGTON RD. - MILWAUKEE, WI 53217

(414) 531-3482

DRS. ELLIE & CARLOS PARAJON ARE PLEASED TO WELCOME YOU TO OUR PRACTICE. PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN. IF YOU HAVE QUESTIONS WE'LL BE GLAD TO HELP YOU. WE LOOK FORWARD TO WORKING WITH YOU IN MAINTAINING YOUR DENTAL HEALTH.

PATIENT INFORMATION

DATE _____ HOME PHONE (____) _____ CELL PHONE (____) _____

NAME _____ SS#/PATIENT ID# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ SEX ___M ___F AGE _____ BIRTHDATE _____

___ MARRIED ___ WIDOWED ___ SINGLE ___ MINOR ___ SEPARATED ___ DIVORCED

PATIENT EMPLOYER/SCHOOL _____ OCCUPATION _____

EMPLOYER/SCHOOL ADDRESS _____ EMPLOYER/SCHOOL PHONE (____) _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

E-MAIL _____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? _____ EMERGENCY PHONE (____) _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____

RELATION TO PATIENT _____ BIRTHDAY _____ SS# _____

ADDRESS _____ PHONE (____) _____

CITY _____ STATE _____ ZIP _____

PERSON RESPONSIBLE EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE (____) _____

INSURANCE COMPANY _____

CONTRACT # _____ GROUP# _____ SUBSCRIBER # _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT _____

DATE OF LAST DENTAL CARE _____ DATE OF LAST DENTAL _____

FORMER DENTIST _____

ADDRESS _____

CHECK IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

- | | | | |
|---------------------------------------------------------|----------------------------------------------------|--------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> BAD BREATH | <input type="checkbox"/> GRINDING TEETH | <input type="checkbox"/> SENSITIVITY TO HOT | <input type="checkbox"/> BLEEDING GUMS |
| <input type="checkbox"/> LOOSE TEETH OR BROKEN FILLINGS | <input type="checkbox"/> SENSITIVITY TO SWEETS | <input type="checkbox"/> CLICKING OR POPPING JAW | <input type="checkbox"/> PERIODONTAL TREATMENT |
| <input type="checkbox"/> SENSITIVITY WHEN BITING | <input type="checkbox"/> FOOD COLLECTION B/W TEETH | <input type="checkbox"/> SENSITIVITY TO COLD | <input type="checkbox"/> SORES IN YOUR MOUTH |

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST VISIT _____

HAVE YOU EVER TAKEN ANY OF THE GROUP DRUGS COLLECTIVELY REFERRED TO AS "FENPHEN?" THESE INCLUDE COMBINATIONS OF LONIMIN, ADIPEX, FASTIN (BRAND NAMES OF PHENTERMINE), PONDIMIN (FENFLURAMINE), AND REDUX (DEXFENFLURAMINE). ____ Yes ____ No

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? ____ Yes ____ No

IF YES, DESCRIBE _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ____ Yes ____ No IF YES, GIVE APPROXIMATE DATES _____

(WOMEN) ARE YOU PREGNANT? ____ Yes ____ No NURSING? ____ Yes ____ No TAKING BIRTH CONTROL PILLS? ____ Yes ____ No

CHECK IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

- | | | | |
|------------------------------|---------------------------|----------------------------|---------------------------------|
| ____ ANEMIA | ____ CORTISONE TREATMENTS | ____ HEPATITIS | ____ SCALET FEVER |
| ____ ARTHRITIS | ____ COUGH, PERSISTENT | ____ HIGH BLOOD PRESSURE | ____ SHORTNESS OF BREATH |
| ____ ARTIFICIAL HEART VALVES | ____ COUGH UP BLOOD | ____ HIV/AIDS | ____ SKIN RASH |
| ____ ARTIFICIAL JOINTS | ____ DIABETES | ____ JAW PAIN | ____ STROKE |
| ____ ASTHMA | ____ EPILEPSY | ____ KIDNEY DISEASE | ____ SWELLING OF FEET OR ANKLES |
| ____ BACK PROBLEMS | ____ FAINTING | ____ LIVER DISEASE | ____ THYROID PROBLEMS |
| ____ BLOOD DISEASE | ____ GLAUCOMA | ____ MITRAL VALVE PROLAPSE | ____ TOBACCO HABIT |
| ____ CANCER | ____ HEADACHES | ____ PACEMAKER | ____ TONSILLITIS |
| ____ CHEMICAL DEPENDENCY | ____ HEART MURMUR | ____ RADIATION THERAPY | ____ TUBERCULOSIS |
| ____ CHEMOTHERAPY | ____ HEART PROBLEMS | ____ RESPIRATORY DISEASE | ____ ULCER |
| ____ CIRCULATORY PROBLEMS | ____ HEMOPHILIA | ____ RHEUMATIC FEVER | ____ VENEREAL DISEASE |

MEDICATIONS: LIST MEDICATIONS YOU ARE CURRENTLY TAKING: _____

ALLERGIES: _____

AUTHORIZATION

I CERTIFY THAT I, AND/OR DEPENDENT(S), HAVE INSURANCE COVERAGE WITH (INSURANCE NAME) _____ AND ASSIGN DIRECTLY TO DR. C & E PARAJON 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.

THE ABOVE-NAMED DENTIST(S) 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 MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE _____ DATE _____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE _____ RELATIONSHIP TO PATIENT _____