WELCOME

TO THE OFFICE OF DR. TODD MANELA

PATIENT INFORMATION

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Today's Date_____ E-Mail Address_____

Name_____Birthdate_____
_ First MI Last
Address_____

Social Security #_____Telephone # (H)_____(W)_____

Phone #s we may use to reach you: Home ( ) Work ( ) Cell ( ) _____
Are you: Male ( ) Female ( ) Married ( ) Single ( ) Divorced ( ) Widowed ( )

You or your parent's employer_____Occupation_____

Business Address_____

Spouse's or Parent's name_____Work Phone #_____

If you are a student, name of school_____Address_____

Whom may we thank for referring you to our office?_____

Person to contact in an emergency_____Phone_____

RESPONSIBLE PARTY
Name of person responsible for this account:_____ _____SS#_____

Relationship to patient_____Home Phone #_____

Address_____

Name of employer_____Work Phone #_____

INSURANCE INFORMATION
Name of insured_____Relationship to patient_____

Name of employer_____Work Phone #_____

Birthdate_____Social Security #_____

Insurance Company_____Group #_____

INSURANCE: We will bill your insurance company as a COURTESY TO YOU. We will assist in all necessary claims submissions in order to obtain payment for your dental services. You are expected to pay your portion of treatment at the time of service. Your insurance carrier's financial responsibility and your co-payment is only an estimate. Anything not covered by your insurance company will be billed to you and payable upon receipt. Remember the ultimate responsibility for payment is yours.
APPONTMENTS: Please remember appointment times are reserved for you. A charge may be made for failed or cancelled appointments without 24 hours prior notice.

CONFIDENTIAL

DENTAL HISTORY

Reason for today's visit_____

What would you like to change about your teeth or smile_____

Former Dentist_____**Date of Last Visit**_____

How often do you brush?_____**How often do you floss?**_____

Do you wear an appliance while sleeping?_____

Please check any of the following conditions that apply to you:

( ) Bad breath	**( ) Grinding teeth**	**( ) Sensitivity to hot/cold**
( ) Bleeding gums	**( ) Loose teeth or broken fillings**	**sweets/pressure**
( ) Clicking or popping of jaw	**( ) Periodontal treatment**	**( ) Sores/growths in mouth**
( ) Food collects between teeth	**( ) Sensitivity to cold**	**( ) Snoring**
( ) Dentures, partials, implants	**( ) Dry mouth**	**( ) Trouble swallowing**

MEDICAL HISTORY

Physician_____**Phone #**_____**Last visit**_____

Please list all medications you are currently taking _____

_____

Herbals_____**Vitamins**_____

Are you allergic to any of the following:

Aspirin NO ( ) YES ( )	**Acrylic NO ( ) YES ( )**	**Penicillin NO ( ) YES ( )**
Latex NO ( ) YES ( )	**Codeine NO ( ) YES ( )**	**OTHER:**

Women: Are you pregnant? NO ( ) YES ( ) Nursing? NO ( )YES ( ) On birth control pills? NO ( ) YES ( )
Hormone replacement therapy? NO ( ) YES ( )

Do you have a history of the following?

( ) Anemia	**( ) Cough Persistent**	**( ) HIV/AIDS**	**( ) Sinus Trouble**
( ) Angina	**( ) Diabetes (I or II)**	**( ) Jaw Pain**	**( ) Skin Rash**
( ) Arthritis, Rheumatism	**( ) Epilepsy**	**( ) Kidney Disease**	**( ) Stroke**
( ) Artificial Heart Valves	**( ) Fainting/Seizures**	**( ) Liver Disease**	**( ) Shortness of Breath**
( ) Artificial Joints	**( ) Glaucoma**	**( ) Mental Health Disorders**	**( ) Swelling Feet/Ankles**
( ) Asthma, Bronchitis,	**( ) Headaches**	**( ) Mitral Valve Prolapse**	**( ) Thyroid Problems**
Emphysema	**( ) Heart Problems**	**( ) Neurological Disorder**	**( ) Tobacco Habit**
( ) Back Problems	**Describe**_____	**( ) Osteoporosis Meds**	**( ) Tuberculosis**
( ) Blood Disease	_____	**( ) Pacemaker**	**( ) Ulcer or Reflux**
( ) Blood Transfusion	_____	**( ) Psychiatric Care**	**( ) Venereal Disease**
( ) Cancer	**( ) Hemophilia**	**( ) Radiation Treatment**	
( ) Chemical Dependency	**( ) Hepatitis**	**( ) Respiratory Disease**	
( ) Chemotherapy	**( ) High Blood Press.**	**( ) Rheumatic Fever**	
( ) Circulatory Problems	**( ) Low Blood Press.**	**( ) Scarlet Fever**	

OTHER MEDICAL ISSUES:_____

AUTHORIZATION:

I understand that I am responsible for all cost of dental treatment and authorize payment of dental benefits directly to this office. I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information contained on this form is correct to the best of my knowledge. I will not hold this dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

FINANCE CHARGE

If I do not pay the entire new balance of my account within 60 days of the billing date, a Finance Charge of 1.5% will be added to the account for each monthly billing period. In the case of default of payment I promise to pay any legal interest on the balance due, along with any collection costs and reasonable attorney fees incurred to effect collection of this account.

SIGNATURE (Patient/Parent/Guardian)_____**Date**_____