Modern Gentle Dentistry

Adult Registration

E. Zambrana, Jr. DDS

Please answer the following questions to the best of your ability. The doctor and hygienist need to know your dental and medical history in order to perform a thorough dental exam.
Please turn your cell phone off before entering the exam room.

Name:_____ Birthday:_____Sex:_____
Address:_____City:_____State:_____Zip:_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Social Security # _____Email Address:_____
Occupation:_____ Employer:_____
Emergency Contact:_____ Relationship:_____Phone:_____

Dental Insurance:_____
Subscriber Name:_____Relationship:_____
Subscriber ID / Social Security # _____ Birthday:_____

How did you hear about Dr. Zambrana's dental practice?
☐ Yellow Pages ☐ Insurance Company ☐ Internet ☐ Referral _____

Are you having problems with your teeth? ☐ Yes _____ ☐ No
Date of your last cleaning:_____

Are you currently under a physician's care? ☐ Yes _____ ☐ No
Reason:_____
_____
Doctor's Name:_____

Women: Are you pregnant? ☐ No ☐ Yes If Yes, how many months?_____

Please list any medications you are currently taking: _____
_____
Please list any medications you are allergic to: _____
_____

Please note any of the following conditions you have or have had in the past ...

☐ Abnormal Bleeding	☐ Arthritis	☐ Asthma
☐ Diabetes	☐ Fainting / Seizures	☐ Hay Fever
☐ Heart Murmur	☐ Heart Trouble	☐ Hepatitis
☐ High Blood Pressure	☐ HIV	☐ Joint Replacement
☐ Kidney Problems	☐ Radiation Treatment	☐ Rheumatic Fever
☐ Stroke	☐ Tuberculosis	☐ Venereal Disease

☐ Other Medical Conditions / Concerns:_____
_____

It is customary to pay in full when initial services are rendered. We will file your insurance for you and reimburse you (minus any co-pays and / or out of pocket expences) once we have received payment from your insurance company. Once we have verified insurance coverage you will be responsible for co-pays and overages for future visits, and we will file for the balance.

Signature:_____ Date:_____