KEVIN D. SESSA, DDS, PC

DENTAL AND MEDICAL HISTORIES-UPDATES

▪ PATIENT INFORMATION ▪

PLEASE PRINT AND COMPLETE ALL ENTRIES

☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FFMALE TODAY'S DATE _____

PATIENT NAME (LAST-FIRST-MIDDLE) _____

DATE OF BIRTH _____ AGE _____ DRIVER'S LIC. # _____ S.S. # _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____ E-MAIL _____

NAME OF EMPLOYER AND ADDRESS _____

WORK PHONE _____ EXTENSION _____ OCCUPATION _____

PARENT OR SPOUSE'S NAME AND ADDRESS _____

PARENT OR SPOUSE'S DATE OF BIRTH _____ AGE _____ S.S. # _____

PARENT OR SPOUSE'S PHONE _____

PARENT OR SPOUSE'S EMPLOYER _____

PARENT OR SPOUSE'S EMPLOYER ADDRESS _____

PARENT OR SPOUSE'S WORK PHONE _____ EXTENSION _____ OCCUPATION _____

CONTACT (NAME AND ADDRESS) _____ PHONE _____

RELATIVE (NAME AND ADDRESS) _____ PHONE _____

IN CASE OF EMERGENCY CONTACT (NAME AND ADDRESS) _____

RELATIONSHIP _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

FAMILY PHYSICIAN _____ PHONE _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____ ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE

INSURANCE INFORMATION

DENTAL INSURANCE _____ PHONE _____

ADDRESS (STREET - CITY - STATE - ZIP) _____

_____

NAME OF INSURED _____ RELATIONSHIP _____

I.D. NO. _____ GROUP NO. _____

SECONDARY DENTAL INSURANCE NAME _____

ADDRESS (STREET - CITY - STATE - ZIP) _____

_____

NAME OF INSURED _____ RELATIONSHIP _____

I.D. NO. _____ GROUP NO. _____

Insurance is a contract between you and your insurance agency. We are NOT a party to this contract in most cases. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductables, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

PATIENT NAME _____ **DATE** _____
FIRST LAST M

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY :

PLEASE CIRCLE

Do you have a specific dental problem? Describe _____ YES NO
Do you have dental examinations on a routine basis? Last visit _____ YES NO
Would you describe your present dental health as good? Comments _____ YES NO
Do you think you have active decay or gum disease? _____ YES NO
Do your gums ever bleed? Discuss _____ YES NO
Do you brush and floss on a routine basis? Discuss _____ YES NO
Do you feel nervous about having dental treatment? _____ YES NO
Have you ever had a bad experience in a dental office? Describe _____ YES NO
Are you happy with your smile? _____ YES NO
Would you like to discuss bleaching your teeth (whitening)? _____ YES NO
Name of previous dentist (optional) _____
Do you ever brux or grind your teeth? Discuss _____ YES NO
Do you prefer to use gas and/or head phones while having dental work performed? _____ YES NO
Have you ever had orthodontic treatment (tooth straightening)? _____ YES NO
Do you ever have clicking, popping, or discomfort in the jaw joints (TMJ)? Discuss _____ YES NO
List main dental complaints _____

MEDICAL HISTORY :

Medical doctor's name _____
Are you under a doctor's care now? Why? _____ YES NO
Have you been hospitalized during the past two years? Why? _____ YES NO
Are you taking any medications, pills, or drugs? What? _____ YES NO
Have you ever had an unusual reaction to dental anesthesia? (shots or gas) _____ YES NO
Are you allergic to any medications or substance? What? _____ YES NO
Are you pregnant? or nursing? (women) _____ YES NO

Please CIRCLE if you have had any of the following:

Heart Trouble	Artificial Heart Valve	Ulcers	Cancer	Hemophilia
High Blood Pressure	Heart Surgery	Allergies	Chemotherapy/Radiation	AIDS
Low Blood Pressure	Stroke	Scarlet Fever	Arthritis/Gout	Cold Sores
Heart Murmur	Diabetes	Asthma	Epilepsy or Seizures	Fever Blisters
Rheumatic Fever	Artificial Joints/Hips	Emphysema	Herpes	Sinus Trouble
Congenital Heart Lesion	Kidney Treatment	Tuberculosis	Anemia	Hypoglycemia

Have you ever had any other serious illness not circled above? _____ YES NO
Please describe in detail _____

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

MEDICAL UPDATES :

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.
DATE PATIENT SIGNATURE

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SERVICE CHARGE :

If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month. Customer hereby acknowledges and agrees that any account that becomes delinquent will be subject to collections service. Customer agrees to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon at 18% (eighteen percent) per annum on all such amounts outstanding.

AUTHORIZATION :

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
PATIENT OR RESPONSIBLE PARTY

_____
DATE