RICHARD GOTTLIEB, DMD

PATIENT INFORMATION

Today's Date_____

Patient Name_____

Address_____

City_____ State_____ Zip_____

Phone: Home_____Work_____Cell_____

E-mail Address_____

Social Security Number_____ **Date of Birth**_____

Preferred Method of Contact: □ Home □ Cell □ Work □ Email

In case of emergency, who should be notified?_____

Phone #_____

Full Time Student? □ Yes □ No **Name of School**_____

Person Responsible for Account(*if different from above***)**_____

Address (*if different from patient*)_____

City_____ State_____ Zip_____

Phone: Home_____ Cell_____

Dental Benefit Plan Information
Primary Dental Plan Name_____ **Phone** _____
Address:_____City_____State_____Zip_____
Name of Insured_____ **Insured's Date of Birth**_____
ID #_____ **Group #**_____
Patient Relationship to Insured_____

Secondary Dental Plan Name_____ **Phone** _____
Address:_____City_____State_____Zip_____
Name of Insured_____ **Insured's Date of Birth**_____
ID #_____ **Group #**_____
Patient Relationship to Insured_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

The following information is essential for the safe and effective diagnosis and treatment of each patient
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

1) Have there been any changes in your general health within the past year? Y / N

2) Congenital Heart Disease/ Heart murmur, rheumatic fever ..... Y N
3) Heart Attack ..... Y N
4) Irregular Heartbeat ..... Y N
5) Angina/Chest pain ..... Y N
6) Heart Surgery ..... Y N
7) Artificial Heart Valve ..... Y N
8) High Blood Pressure ..... Y N
9) Low Blood Pressure ..... Y N
10) Stroke/Paralysis ..... Y N
11) Chest Pain ..... Y N

RESPIRATORY

12) Asthma ..... Y N
13) Breathing Problem (Sleep Apnea... Y N
Emphysema, Shortness of Breath, Oxygen Dependent, Cough)
14) Tuberculosis ..... Y N

GATRO-INTESTINAL

15) Kidney Disease ..... Y N
16) Liver Disease ..... Y N
17) Stomach/Intestinal Disease/Ulcers Y N
Reflux

NEUROLOGY

18) Convulsions/Seizures/Epilepsy ..... Y N
19) Numbness or tingling/ back pain... Y N
20) Dizziness/Headaches..... Y N

ENDOCRINE

20) Diabetes ..... Y N
21) Steroid treatment (Cortisone) ..... Y N

HEMATOLOGY

22) Bleeding/Bruising Easily/ Blood Disorder ..... Y N
23) Blood Thinner ..... Y N
24) Immune System ..... Y N
(Lupus, Immunodeficiency, Sjogren's)

INFECTIOUS DISEASE

25) HIV/AIDS ..... Y N
26) Herpes ..... Y N
27) Hepatitis A, B, or C ..... Y N

MUSCULOSKELETAL

28) Rheumatism/Arthritis/Pain in joints .... Y N
29) Artificial Joint ..... Y N

GENERAL

30) Current Cancer ..... Y N
31) Past Cancer ..... Y N
32) Radiation Therapy ..... Y N
33) Chemotherapy ..... Y N
34) Hives/Rash ..... Y N
35) Difficulty Hearing ..... Y N
36) Eye Problems (Dry Eyes/Glaucoma) ..... Y N
37) Smoke/Vape/Tobacco use..... Y N
38) Recreational Drug use..... Y N

Women

39 Are you pregnant? ..... Y N
40) Are you nursing? ..... Y N

41) Have you experienced an unusual or allergic reaction to any of the following?

_____ Local Anesthetic _____Codeine
_____ Penicillin _____Narcotics
_____ Sulfa Drugs _____ Latex Rubber
_____ Aspirin _____ Metals
_____ Others_____

42) Have you had any serious trouble associated with any previous dental treatment? _____
43) Have you ever been told that you need antibiotic medication before dental treatment? Y N
44) Are you taking a Bisphosphonate drug for Osteoporosis (Boniva, Fosamax, Zometa, etc..) Y N

List any medications that you are taking:

	Medication	**Reason**
1.		
2.		
3.		
4.		
5.		
6.		

Please list any hospitalizations you have had:

Date(Year)	**Surgery**	**Reason**

45) Are you under the care of a Physician? Y / N

Primary Physician's Name_____ Physician's Phone #:_____

46) Do you have any other condition or problem not listed above that we should know about?

If so, please explain_____

_____

47) Have you been vaccinated against COVID-19? Y / N

I CERTIFY THAT ALL THE INFORMATION I HAVE PROVIDED IS TRUE TO MY KNOWLEDGE:

Patient's Signature_____ Date_____

GENERAL CONSENT TO DIAGNOSE AND TREAT:

The undersigned hereby authorizes Richard Gottlieb, DMD to employ the use of radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my/the patient's dental condition and needs. No dental problem ever gets better on it own. All dental problems are progressive and the challenge is to find them, the causes for each, and then create a definitive plan for treatment. We also need to figure out a way to take care of the important problems first along with issues of cost, time, and other factors in your life. Just as there may be risks and hazards in continuing in the present condition you are in without treatment, there are also risks related to the procedures planned, including tooth sensitivity to hot, cold , sweet or biting, infection, additional or unexpected treatment, pain, or discomfort after the procedure, temporary numbness, difficulty to open or close, jaw joint injury or muscle spasm, cracking or bruising of the corners of the mouth, lips, or tongue, and accidental swallowing of foreign objects. I authorize Richard Gottlieb, DMD to perform any and all forms of treatment, medication, and therapy that may be necessary and as will be discussed, and further consent that Richard Gottlieb, DMD choose and employ such assistance as he deems necessary. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health, status, or medications.

FINANCIAL CONSENT:

I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, and that such payment is due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental insurance. I acknowledge that I am responsible for all fees and costs necessary to collect my account. I authorize Richard Gottlieb, DMD and his staff to submit a claim on my behalf and that it is my responsibility to provide them with the necessary insurance coverage if any. I understand if I do not provide the proper insurance information, that I am responsible for all fees at the time services are rendered.

_____
INITIALS

INSURANCE:

To avoid any misunderstanding regarding dental insurance, we wish our patients to know that Richard Gottlieb, DMD is a non-participating provider with all insurances. We will prepare all necessary forms or reports to help you obtain your benefits from insurance companies. **WE DO NOT RENDER OUR SERVICES ON THE BASIS THAT THE INSURANCE COMPANIES WILL PAY ALL OF OUR FEES. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLES, CO-INSURANCES, OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE COMPANY.**

I certify that I have read and understand the above and I acknowledge that my questions, if any, about the above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of the form.

Name of Patient _____ **Date:**_____

Signature of Patient/Parent or Guardian_____