WELCOME

Elizabeth Spindel, DMD
Victoria Spindel Rubin, DMD

Name: ____ **Nickname:** _________________________

Address: __________________________________ **City:** ________________ **State:** ____ **Zip:** _________

Home #________________________________ Date of Birth: ______/______/______
Work #_________________________________ Social Security # ___________________________
Cell #___________________________________ E-Mail Address: ___________________________

Primary Dental Insurance Information:

Policy Holder Name _________________________________ Date of Birth: ______/______/______
Employer ____ Social Security # ___________________

Name of Insurance Company __________________________ Group #__________________________
Address ____ ID# _____________________________
____ Phone #__________________________

Secondary Dental Insurance Information:

Policy Holder Name _________________________________ Date of Birth: ______/______/______
Employer ____ Social Security # ___________________

Name of Insurance Company __________________________ Group #__________________________
Address ____ ID# _____________________________
____ Phone #__________________________

Person Financially Responsible for Account: ____

I herby authorize assignment of my insurance rights and benefits directly to the provider for service rendered. I fully understand I am solely responsibly for any balance not paid for by my insurance company.

Name: (please print) ***Signature***

_____________________________________ _____________________________________

(please continue on back)

Medical Information:

Primary Care Physician ______________________________ Phone ______________________________

Do you have or ever had any of the following conditions? (Please circle)

Heart attack	Kidney problems	Cancer	Tumors
Heart surgery	Liver problems	Asthma	Anemia
Heart murmur	Hepatitis	HIV/AIDS	Leukemia
Pacemaker	Hypoglycemia	Diabetes	Emphysema
Heart disease	Rheumatic fever	Epilepsy	Drug abuse
Artificial valves	Bleeding problems	Scarlet fever	Alcohol abuse
Congenital heart defect	Stomach problems	Sinus problems	Arthritis
Mitral valve prolapse	Severe headaches	Chest pains	Depression
High blood pressure	Eating disorder	Tuberculosis	Stroke
Low blood pressure	Psychiatric problem	Thyroid problems	Seizures
Artificial bones/joints	Fainting problem	Chemotherapy	Cold sores
Radiation	Asperger	Autism	Acid reflux

Please list any other medical conditions: ____
____

Current medications: ____
____

Do you require premedication? **Y** or **N** If so, what medication? __________________________________

Are you taking or have you taken Bisphosphonates (to increase bone density) Ex: Fosamax **Y** or **N**

Allergies: (Please check any of the following)

Latex ________ Penicillin/Amoxicillin __________ Metals __________

Codeine _____ Dental Anesthetics _____________ Other ___________

Tobacco use: **Y** or **N** How much _______________ How many years _______________

Dental Information: (Please check any of the following)

__ red, swollen or bleeding gums __broken/lost fillings __ stained teeth

__ sensitive teeth or gums __ bad breath __ sores in mouth

__ food sticking between teeth __ grinding/clenching __chipped teeth

How often do you brush? ______________ Floss? ______________ Waterpik? ______________

- Are you happy with the color of your teeth? **Y** or **N**
- Would you be interested in whitening your teeth? **Y** or **N**
- Would you be interested in straightening your teeth with INVISALIGN? **Y** or **N**
- Do you have a snoring problem? **Y** or **N**
- Do you have sleep apnea? **Y** or **N**

If you could change anything about your smile what would it be?__________________________________