

PATIENT INF	ORMAT	ION:								Dr	. Bria	an Sz	akaly	, D.D.S.
Patient Name:								Soc	Social Security Number: Today's Date					
Home Address:					ja j		City	:				State	Zip Code:	
Date of Birth:	Sex: M F	Age:	Marital S	tatus:	Home Pho	ne Numb	er: Co	ell Pho	ne N	lumber:	Stu	udent? Yes N		No
Employer:										Wo	rk Ph	one N	umbe	r:
Employer Addr	ess:						City	:				State	e:	Zip Code:
DENTIST:				PHYS	ICIAN:	- 4				REFERRE	D BY:			
Nearest Relativ	e/Friend	(Emerge	ency Conta	ct):						Phone N	lumbe	r:		
Address:							City	:				State	e:	Zip Code:
PRIMARY RE	SPONSI	BLE PA	RTY: (Co	mplete	e if differe	nt than	Patier	t Info	orm	ation):				
Relationship to	Patient:	N	ame:								Soci	al Sec	urity l	Number:
Address:			Ci	ity:		State:	Zip C	ode:	Hor	me Phon	e Num	nber:	Cell	Phone Numbe
Date of Birth:	Sex: M F	Marita	al Status:											
Employer:												Wor	k Phoi	ne Number:
Employer Addr	ess:						City:					State:		Zip Code:
INSURANCE:	0 1000	100	SURANCE	:										
Insurance Com	pany Nam	ne:												
Name of Policy	Holder:					23	Date of Birth:				Social Security Number:			
Policy Number:								-	- )	Group N	umbe	r:		
Address of Poli	cy Holder	:					City	:				State	:	Zip Code:
	DENT	AL INS	JRANCE:											
Insurance Com	pany Nam	ne:												
Name of Policy Holder:							Date of Birth:				Social Security Number:			
Policy Number:										Group N	umbe	r:		
Address of Policy Holder:							City:				State			State:
nsurance Com			RANCE:	X MED	DICAL	X DENT	AL							
Name of Policy	Holder:						Date o	of Birt	h:	!	Social	Secur	ity Nu	mber:
Policy Number:									G	roup Nur	nhor			

## FINANCIAL AGREEMENT:

## INSURANCE AUTHORIZATION AND AGREEMENT

As a courtesy to our patients, we complete and file insurance forms. It is your responsibility to provide insurance forms, which are completely filled out and signed with benefits assigned to our physician(s). If your insurance company fails to pay your claim, payment is your responsibility regardless whether or not your insurance company deems such procedure(s) medically or dentally necessary.

This office does not determine the benefits under your insurance policy unless requested. If you have specific questions please contact your insurance carrier or employer.

I hereby authorize Dr. Szakaly to furnish information to insurance carriers concerning my treatment and I hereby assign to the physician(s) all payments for services rendered to me or my dependents.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Email address:	
SIGNATURE OF PATIENT OR GUARDIAN	DATE
Your insurance may not deem your intravenous anesthesia or any surg therefore making the patient/guardian responsible for payment.	gical procedure medically necessary,
If you cancel with less than 48 hours notice from the time of your app \$25 for an office visit and \$50 for a surgery.	pointment, you will be charged a fee of
I agree to be responsible for my account. In the event that my account terms of this account and my account is referred to a collection agency responsible for all of their fees which includes attorney's fees of 33 1/3 costs expended.	y and/or attorney for collections, I will be
PAYMENT AGREEMENT	
SIGNATURE OF PATIENT OR GUARDIAN	DATE



## **Medical History Form** Dr. Brian Szakaly D.D.S. Name: Sex M/F Date: Date of Birth Height Weight Age General Dentist \_\_\_\_\_ Referral Source (if different from dentist) Occupation Reason for visit today/chief dental complaint For the following questions, circle yes or no, whichever applies? Your answers are for our records only and will be kept confidential. 1. My last physical exam was on \_\_\_\_/\_\_\_/ 2. Are you under the care of a physician? Yes No 3. The name of my physician is 4. Have you had any serious illness, operation or hospitalization within Yes No the past five years. 5. Have you had an artificial joint replacement (knee, hip, shoulder, etc.) Yes No 6. Do you have a serious congenital heart condition Yes No 7. Do you have a history of infective endocarditis Yes No 8. Are you taking or have you ever taken Bisphosphonates for osteoporosis? Yes No No or chemotherapy for multiple myeloma or other cancers (Fosamax, Actonel Yes Boniva, Aredia, or Zometa? 9. Do you have or have you had any of the following diseases or problems? Yes No Damaged heart valves, artificial valves or heart murmur Yes No Heart attack, angina, high blood pressure. Stroke Yes No Arteriosclerosis, cholesterol problems or any other heart condition. Yes No (please circle all that apply) a. Damaged heart valves, artificial valves or heart murmur Yes No Heart trouble, heart attack, angina, high blood pressure, stroke, Yes No Arteriosclerosis cholesterol problems or any other heart condition (Please circle all that apply) 1. Chest Pain upon exertion? Yes No 2. Shortness of breath after mild exercise Yes No Asthma or hay fever Yes No Respiratory problems, emphysema, bronchitis, tuberculosis, etc. Yes No e. Persistent cough or cough that produces blood Yes No f. Sleep Apnea Yes No Persistent swollen neck glands Yes No h. Fainting spells Yes No Epilepsy or neurological disorder i. Yes No j. Diabetes Yes No k. Hepatitis, jaundice or liver disease Yes No Thyroid problems 1. Yes No

Yes

Yes

Yes

No

No

No

m. Arthritis or painful, swollen joints including jaw joint (TMJ)

Osteoporosis

Stomach ulcer or hyperacidity

n.

q. Anny disease, drug or transplant operation that has depressed your immers system?  10. Have you had abnormal bleeding?  11. Have you had abnormal bleeding?  11. Do you have any blood disorder such as anemia (including sickle cell anemia)  12. Have you ever had treatment for a tumorigrowth (i.e. carcery?  13. Have you had radiation therapy to the head neck or jaws?  14. Are you taking any of the following medications:  15. Are you taking any of the following medications:  16. Anticoagulants (blood thinners)  17. C. Medication for high blood pressure  18. Anticoagulants (blood thinners)  19. C. Medication for high blood pressure  19. C. Anticoagulants (blood thinners)  19. C. Medication for high blood pressure  19. Antihalistamine  19. Antihalistamine  19. Antihalistamine  19. Codeine or other narcotics  19. No  19. Antihalistamine  19. Codeine or other narcotics  19. No  19. Codeine or other narcotics  19. No  19. Latex or rubber products  19. Do you have any other condition or disease you think the doctor should know about?  19. Do you have any other condition or disease?  19. Are you wearing removable dental appliances?  20. Latex or rubber products  21. Are you waring removable dental appliances?  22. Are you pregnant or trying to become pregnant  23. Are you pregnant or trying to become pregnant  24. S. No  25. Are you waring removable dental appliances?  25. Are you pregnant or trying to become pregnant  26. Are you pregnant or trying to become pregnant  27. Do you have a sexually transmitted disease? (Gonorrhea.syphilis.genital warts, HIV, AIDS?  28. No  29. Are you waring removable dental appliances?  29. No  20. Do you smoke or chew tobacco?  20. Do you smoke or chew tobacco?  20. Are you pregnant or trying to become pregnant  29. No  20. Do you smoke or chew tobacco?  20. The you waring removable dental appliances?  20. Do you smoke or chew tobacco?  20. Do you s	<ul> <li>p. Kidney trouble</li> </ul>						Yes	No		
11.Do you have any blood disorder such as anemia (including sickle cell anemia) 12. Have you ever had treatment for a tumor/growth (i.e. caneer)? 13. Have you over had treatment for a tumor/growth (i.e. caneer)? 14. Are you taking any of the following medications:  15. Are you taking any of the following medications:  16. Are journal for high blood pressure  17. Aspirin, ibuprofen (Advil or Motrin)  18. Do you allergic to any of the following medications or products?  18. Are you allergic to any of the following medications or products?  19. Cocal Anesthestics  19. No  19. Island and sheeting in a thick is a social and the products of the following medications or products?  19. Are you allergic to any of the following medications or products?  19. Local Anesthestics  19. No  19. Have you have any other condition or disease you think the doctor should know about?  19. Do you have a sexually transmitted disease?  19. Do you have a nervous/psychiatric condition (including depression/anxiety)?  19. Are you making any of the following medications?  19. Do you have a sexually transmitted disease?  19. No  20. Do you smoke or chew tobacco?  19. As you sum of the following medications?  19. Do you have any other condition of including depression/anxiety)?  20. Do you smoke or chew tobacco?  21. Do you have a product of the disease?  22. Are you wearing removable dental appliances?  23. Are you pregnant or trying to become pregnant  24. So 24. Do you have problems with your menstrual period? Yes No  25. Are you pragnant or trying to become pregnant  28. Are you pregnant or trying to become pregnant  29. No  20. Do you wish to talk with the doctor privately?  20. Do you wish to talk with the doctor privately?  20. Do you wish to talk with the doctor privately?  20. Do you wish to talk with the doctor privately?  20. Do you wish to talk with the doctor privately?  20. Do you wish to talk with the doctor privately?  20. Do you wish to talk with the doctor privately?  21. Do you have problems with your menstrual period? Yes		olant opera	tion that	has dep	oressed yo	ur	Yes	No		
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12. Have you lear that treatment for a tumor/growth (i.e. career)?  13. Have you had radiation therapy to the head neck or jaws?  14. Are you taking any of the following medications:  15. Are you taking any of the following medications:  16. Are included the problem of the following medications:  17. Are you allergic to any of the following medications to result all other medications to taking.  18. Are you allergic to any of the following medications or products?  19. Local Anesthestics  19. No  19. Loca	The state of the s							No		
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14. Are you taking any of the following medications:								No		
14. Are you taking any of the following medications:		Yes	No							
a. Antibiotic or sulfa drug b. Anticoagulants (blood thinners) c. Medication for high blood pressure d. Cortisone (steroids (including prednisone) e. Tranquilizers f. Aspirin, ibuprofen (Advil or Motrin) f. Are you allergic to any of the following medications or etc. f. Other (inc diet pills, herbal, homeopathic or etc.) f. Are you allergic to any of the following medications or products?  Local Anesthestics f. Aspirin f. A							Please list wh	ich one:		
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c. Medication for high blood pressure  d. Cortisone (steroids (including prednisone)  e. Tranquilizers  Yes No  g. Insulin  Yes No  g. Insulin  Yes No  j. Aspirin, ibuprofen (Advil or Motrin)  j. Antihistamine  k. Other (inc diet pills, herbal, homeopathic or etc Yes No  l. Please list all other medications taking:  15. Are you allergic to any of the following medications or products?  Local Anesthestics  Yes No  Local Anesthestics  Yes No  Sulfa Drugs,  Yes No  Latex or rubber products  Yes No  If so explain:  17. Do you have any other condition or disease you think the doctor should know about?  Yes No  If so explain:  19. Do you have a nervous/psychiatric condition (including depression/anxiety)?  Yes No  21. Do you drink alcohol beverages?  Yes No  Other?  19. Do you have a sexually transmitted disease? (Gonorrhea.syphilis.genital warts, HIV, AIDS? Yes No  22. are you wearing removable dental appliances?  Yes No  If so explain:  19. Do you have a sexually transmitted disease? (Gonorrhea.syphilis.genital warts, HIV, AIDS? Yes No  22. are you wearing removable dental appliances?  Yes No  If so explain genovable dental appliances?  Yes No  24. Do you drink alcohol beverages?  Yes No  If so explain genovable dental appliances?  Yes No  25. Are you pregnant or trying to become pregnant  Yes No  I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.	b. Anticoagulants (blood thinner	rs)			Yes	No				
d. Cortisone (steroids (including prednisone) e. Tranquilizers f. Aspirin, ibuprofen (Advil or Motrin) g. Insulin h. Digitalis (Drugs for heart failure) j. Antihistamine k. Other (inc diet pills, herbal, homeopathic or etc Yes No l. Please list all other medications taking:  15. Are you allergic to any of the following medications or products? Local Anesthestics Yes No Penicillin or antibiotics Yes No Sulfa Drugs Sulfa Drugs Sulfa Drugs Yes No Other?  16. Have you have an ervous/psychiatric condition (including depression/anxiety)?  17. Do you have an ervous/psychiatric condition (including depression/anxiety)?  18. Do you have a sexually transmitted disease? (Gonorrhea,syphilis,genital warts, HIV, AIDS? Yes No Others 19. Do you have a sexually transmitted disease? (Gonorrhea,syphilis,genital warts, HIV, AIDS? Yes No Others 21. Are you pregnant or trying to become pregnant Yes No 14. Do you have problems with your menstrual period?Yes/No Others 22. are you wearing removable dental appliances? Yes No 14. Do you have problems with your menstrual period?Yes/No Others 23. Are you pregnant or trying to become pregnant Yes No 14. Do you have problems with your menstrual period?Yes/No Do you wish to talk with the doctor privately? Yes No 15. Are you pregnant or trying to become pregnant Yes No 16. Are you pregnant or trying to become pregnant Yes No 16. Are you taking oral contraceptive/hormonal therapy?Yes/No Do you wish to talk with the doctor privately? Yes No 16. Are you pregnant or trying to become pregnant Yes No 16. Are you taking oral contraceptive/hormonal therapy?Yes/No Do you wish to talk with the doctor privately? Yes No Do you wish to talk with the doctor privately? Yes No Do you wish to talk with the doctor privately? Yes No Do you wish to talk with the doctor privately? Yes No Do you wish to talk with the doctor privately? Yes No Do you wish to talk with the doctor privately? Yes No	And a color and a					No				
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k. Other (ine diet pills, herbal, homeopathic or etc Yes No  1. Please list all other medications taking:  15. Are you allergic to any of the following medications or products?  Local Anesthestics Yes No Sulfa Drugs Yes No Penicillin or antibiotics Yes No Barbiturates or sleeping Pills Yes No Aspirin Yes No Iodine Yes No Codeine or other narcotics Yes No Latex or rubber products Yes No Other?  16. Have you had any serious trouble associated with previous dental treatment? Yes No If so explain:  17. Do you have any other condition or disease you think the doctor should know about? Yes No If so, explain  18. Do you have a nervous/psychiatric condition (including depression/anxiety)? Yes No If so please explain;  19. Do you have a sexually transmitted disease? (Gonorrhea,syphilis,genital warts, HIV, AIDS? Yes No 20. Do you smoke or chew tobacco? Yes No 21. Do you drink alcohol beverages? Yes No Women: 23. Are you pregnant or trying to become pregnant Yes No 24. Do you have problems with your menstrual period?Yes/No 25. Are you nursing? Yes No  I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.	i. Nitroglycerin				Yes	No				
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15. Are you allergic to any of the following medications or products?  Local Anesthestics Yes No Sulfa Drugs, Yes No Penicillin or antibiotics Yes No Barbiturates or sleeping Pills Yes No Aspirin Yes No Iodine Yes No Codeine or other narcotics Yes No Latex or rubber products Yes No Other?  16. Have you had any serious trouble associated with previous dental treatment? Yes No If so explain: 17. Do you have any other condition or disease you think the doctor should know about? Yes No If so, explain 18. Do you have a nervous/psychiatric condition (including depression/anxiety)? Yes No If so please explain; 19. Do you have a sexually transmitted disease? (Gonorrhea,syphilis,genital warts, HIV, AIDS? Yes No 20. Do you smoke or chew tobacco? Yes No 21. Do you drink alcohol beverages? Yes No Women: 23. Are you pregnant or trying to become pregnant Yes No Ves No 24. Do you have problems with your menstrual period?Yes/No 25. Are you nursing? Yes No I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.	k. Other (inc diet pills, herbal, h	omeopathi	c or etc.		Yes	No				
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Local Anesthestics Yes No Burbitrates or sleeping Pills Yes No Aspirin Yes No Iodine Yes No Codeine or other narcotics Yes No Latex or rubber products Yes No Other?  16. Have you had any serious trouble associated with previous dental treatment? Yes No If so explain:  17. Do you have any other condition or disease you think the doctor should know about? Yes No If so, explain 18. Do you have a nervous/psychiatric condition (including depression/anxiety)? Yes No If so please explain;  19. Do you have a sexually transmitted disease? (Gonorrhea, syphilis, genital warts, HIV, AIDS? Yes No 20. Do you smoke or chew tobacco? Yes No 21. Do you drink alcohol beverages? Yes No Women:  23. Are you wearing removable dental appliances? Yes No 26. Are you taking oral contraceptive/hormonal therapy?Yes/No 27. Do you wish to talk with the doctor privately? Yes No  I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.										
Penicillin or antibiotics Yes No Barbiturates or sleeping Pills Yes No Aspirin Yes No Iodine Yes No Codeine or other narcotics Yes No Latex or rubber products Yes No Other?  16. Have you had any serious trouble associated with previous dental treatment? Yes No If so explain:  17. Do you have any other condition or disease you think the doctor should know about? Yes No If so, explain  18. Do you have a nervous/psychiatric condition (including depression/anxiety)? Yes No If so please explain;  19. Do you have a sexually transmitted disease? (Gonorrhea, syphillis, genital warts, HIV, AIDS? Yes No  20. Do you smoke or chew tobacco? Yes No 21. Do you drink alcohol beverages? Yes No  Women:  23. Are you wearing removable dental appliances? Yes No 24. Do you have problems with your menstrual period?Yes/No  25. Are you nursing? Yes No 26. Are you taking oral contraceptive/hormonal therapy?Yes/No  I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.	15. Are you allergic to any of the following	ng medica	tions or	product	s?					
Aspirin Yes No Iodine Yes No Codeine or other narcotics Yes No Latex or rubber products Yes No Other?  16. Have you had any serious trouble associated with previous dental treatment? Yes No If so explain:  17. Do you have any other condition or disease you think the doctor should know about? Yes No If so, explain  18. Do you have a nervous/psychiatric condition (including depression/anxiety)? Yes No If so please explain;  19. Do you have a sexually transmitted disease? (Gonorrhea,syphilis,genital warts, HIV, AIDS? Yes No 20. Do you smoke or chew tobacco? Yes No 21. Do you drink alcohol beverages? Yes No Women: 23. Are you wearing removable dental appliances? Yes No Women: 24. Do you have problems with your menstrual period?Yes/No 25. Are you nursing? Yes No 26. Are you taking oral contraceptive/hormonal therapy?Yes/No 27. Do you wish to talk with the doctor privately? Yes No  I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.	Local Anesthestics	Yes	No		Sulfa	Drugs.		Yes	No	
Codeine or other narcotics Yes No  Other?  16. Have you had any serious trouble associated with previous dental treatment?  17. Do you have any other condition or disease you think the doctor should know about?  18. Do you have a nervous/psychiatric condition (including depression/anxiety)?  19. Do you have a sexually transmitted disease? (Gonorrhea,syphilis,genital warts, HIV, AIDS? Yes No  20. Do you smoke or chew tobacco?  21. Do you drink alcohol beverages?  22. are you wearing removable dental appliances?  23. Are you pregnant or trying to become pregnant  24. Do you have problems with your menstrual period?Yes/No  25. Are you nursing?  26. Are you taking oral contraceptive/hormonal therapy?Yes/No  27. Do you wish to talk with the doctor privately?  Yes No  I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.	Penicillin or antibiotics	Yes	No		Barbi	turates or s	leeping Pills	Yes	No	
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answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.	I have read and t	inderstand	the abov	ve. Anv	questions	I had abou	t this form have	been		
					•				nd comple	etely.