Lilia S Fiat, DMD LLC

Last Name_____ **First Name** _____ **M initial** _____

Home address_____ **City** _____ **State** _____**Zip**_____

Home phone_____ **Cell** _____**Work** _____

Email_____ **Social Security** _____**Birth date** _____

Employer_____ **If Student School** _____ ☐ **F/T** ☐ **P/T**

Contact in Case of Emergency_____ **Telephone Number** _____

How did you hear of our office? _____

Insurance / Account Information

Last Name of Insured_____ **First Name** _____

Home Address _____ **City** _____ **State** _____ **Zip**_____

Home Telephone_____ **Date of Birth** _____

Social Security Number_____ **Dental Plan**_____

Insured's relationship to Patient_____ **Employer Sponsoring Plan** _____

Insurance I.D. Number_____ **Group Number**_____

Please Read and Sign Below

Payment is Due in Full
Upon Services Rendered

If you have insurance coverage our staff will calculate Estimated insurance payments for services rendered. We Can not, however be responsible for actual payment made by your insurance carrier. You are required to make payment for your full estimated responsibility upon services rendered. After payments are received from your insurance carrier, you may be required to make additional payments or have a credit returned to you.

_____

Signature of patient/ guardian Date

Patient Dental History

Previous Dentist _____ **Location** _____ **Date of last exam** _____

Reason for changing previous Dentist _____

What is purpose of today's visit? _____

Do you have/ have you had any of the following? **YES** **NO**

1) Teeth sensitivity to heat?
2) Teeth sensitive to cold?
3) Teeth sensitive to sweets?
4) Teeth sensitive when biting?
5) Pain in any of your teeth?
6) Swelling in your face or mouth?
7) Problems with previous dental treatment?
8) Bleeding gums?
9) Loose Teeth?
10) Do you like your smile?

Any concerns that you would like the Dentist to review with you? _____
_____

Authorization and Release

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child during the period of such dental care to third party payors and/or health practitioners.

_____
Signature of patient/guardian **Date**

Office use only
I verbally reviewed the medical/dental information with patient named herein.
Doctors Signature _____ **Date** _____
Doctors Comments _____
1) Date: _____ **Changes yes/no Comments:** _____ **Initials** ____
2) Date: _____ **Changes yes/no Comments:** _____ **Initials** ____