ADVANCE
DENTAL
CARE

Cosmetic & Family Dentistry- Specialist on Site
Sherry Maz, DMD
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Patient Information

Patient Name:
First Middle Name Last Name (Preferred / Nickname)

Biological Gender: ☐ Male ☐ Female

Family Status: ☐ Single ☐ Married ☐ Divorced ☐ Child ☐ Other

Social Security #*:*

Birth Date:

Phone- Cell Number:

Work/Alternate Phone Number:

E-Mail:

Street Address:
Apartment #:
City:
State:
Zip Code:

Parent /Spouse or Responsible Party Information- If other than the above patient
The following is for: ☐ the patient's spouse ☐ the parent ☐ the person responsible for payment

Name:
☐ Male ☐ Female

Social Security #:
Birth Date:

Cell Phone Number:
Address if different than patient:

Referral Information

Name of your referral (Required):

Whom may we thank for referring you to our practice?
Another patient, friend, Dr. Maz, team member- please write the name of your referral above:

☐ Dental Office ☐ Google search ☐ Yelp ☐ Insurance Rep or website ☐ Location/drive by ☐ Other internet site

Health Information

Date of Last Dental Visit:
Reason for this visit:

Have you ever had any of the following? ***Please check those that apply:***

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____

- Name the medication you're currently taking:
- Do you need to alter any medications before dental treatment or need to pre-medicate with antibiotic prophylaxis before you cleaning? If yes, please explain:
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:
- Have you been admitted to a hospital or needed emergency care during the past two years? Any metal or foreign objects in your body ? If yes, please explain:
- Are you now under the care of a physician? Do you have any health problems that need further clarification? If yes, please explain why:
- Name of Physician:
  Phone and/ or Email address:

Insurance Information

Email us the copy of your insurance card- Please bring it with you to scan in your chart

Primary Insurance:
Insurance Plan Name:
Group Number (Required):
Claim Address:
Payor ID number (if you know it)

If your plan is under another person: Name of Insured:
Birthdate: Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance:

Patient Signature

Please print this sheet and bring it with you (even if you email it to us)- Thank you

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors immediately without fail.

Signature of patient, parent or guardian:

Date: Relationship to Patient: