CHAMPIONSHIP
D-E-N-T-A-L

1 PATIENT INFORMATION

Date_____________

Patient__________________________ Sex: □M □F
Date of Birth________________________________

Address_____________________________________

____
City State Zip

□Single □Married □Widowed □Separated □Divorced

Patient SS#___________________________________
Employer_____________________________________
Employer Phone Number__________________________

Spouse's Name_________________________________
Date of Birth_________________ SS#_____________
Spouse's Employer______________________________

Referral Source:_______________________________

2 DENTAL INSURANCE

Subscriber Name _______________________________
Relationship to Patient__________________________
Subscriber SSN_________________________________
Date of Birth__________________________________
Primary Insurance Co.___________________________
Group#_______________________________________
Secondary Insurance Co._________________________
Group#_______________________________________

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Marisol Vargas all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____
Relationship Date

3 PHONE NUMBERS

Mobile_______________ Home___________________ Email____

IN CASE OF AN EMERGENCY, CONTACT (specify someone who does not live in your household.)

Name________________________ Relationship__________________________ Phone Number _________________

REASON FOR TODAY'S VISIT:
____
____

4 MEDICATIONS

List the medications you are currently taking:__________
____
____
____
____

Pharmacy Name___________________ Phone_________

5 ALLERGIES

□ Asprin
□ Barbiturates (sleeping pills)
□ Codeine
□ Iodine
□ Local Anesthetic
□Latex
□ Penicillin
□ Sulfa
□ None
□ Other____________

6 HEALTH HISTORY

Physician's Name_____________________ Phone_________________ Date of Last Visit ______________

Please mark "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	□Y□N	Asthma	□Y□N	Diabetes	□Y□N	Ulcer	□Y□N
Herpes	□Y□N	Emphysema/COPD	□Y□N	Hepatitis	□Y□N		
Abnormal Bleeding	□Y□N	Respiratory Disease	□Y□N	Kidney Disease	□Y□N		
Anemia	□Y□N	Shortness of Breath	□Y□N	Liver Disease	□Y□N		
Blood Disease	□Y□N	Tuberculosis	□Y□N	Epilepsy/Convulsions	□Y□N		
Circulatory Issues	□Y□N	Sinus Issues	□Y□N	Fainting/Dizziness	□Y□N		
Angina	□Y□N	Back Issues	□Y□N	Glaucoma	□Y□N		
Heart Issues	□Y□N	Cancer	□Y□N	Headaches	□Y□N		
Heart Murmur	□Y□N	Chemotherapy	□Y□N	Nervousness	□Y□N		
High Blood Pressure	□Y□N	Radiation Treatment	□Y□N	Psychiatric Care	□Y□N		
Low Blood Pressure	□Y□N	Tumor	□Y□N	Swollen Neck Glands	□Y□N		
Pace Maker	□Y□N	Arthritis	□Y□N	Thyroid/Parathyroid	□Y□N		
Stroke/Heart Attack	□Y□N	Cortisone Treatment	□Y□N	Pregnant	□Y□N		

IF YOU CHECKED YES TO ANY OF THE ABOVE PLEASE EXPLAIN:________________________________
____
____

7 DENTAL HISTORY

Date of last dental visit: ___________________ Date of Last X-rays__________________

Please mark " Yes" OR "No" to indicate if you have had any of the following:

Bad Breath	□Y□N	Clicking/Popping Jaw	□Y□N	Jaw Pain/Tiredness	□Y□N	Pain around Ear	□Y□N
Bleeding Gums	□Y□N	Dry Mouth	□Y□N	Lip/Cheek Biting	□Y□N	Sensitivity to Hot/Cold	□Y□N
Blisters on Lip/Mouth	□Y□N	Fingernail Biting	□Y□N	Mouth Breathing	□Y□N	Tobacco Use	□Y□N
Burning on Tongue	□Y□N	Grinding Teeth	□Y□N	Mouth Pain	□Y□N	Alcohol Use	□Y□N
Chewing on one side of mouth	□Y□N	Gums Swollen/Tender	□Y□N	Orthodontic Treatment	□Y□N		