

VALERIA SOLTANIK, DMD P.A. 2999 NE 191st street Suite 350 • Aventura, FI 33180 • 305-466-2334

			Chart Number	
Patient's Name	First		Middle	
			Marital Status	
MM DD YY	Journal Jecumy 140	Gex (Min)	Marital Status	
Aduress Fmail		Homo Dhono	-	
Work Phone	 Mobile			
	PartyOccupatio			
INSURANCE: Yes / No: Insura	nce Company	Name of Subscriber	÷	
How were you referred to our	office?	DD YY	nip with Patient	
•	MEDICAL HIS			
YES NO Are you in good health? Have you ever had any serious illness or operations? Damaged or artificial heart valves; rheumatic fever? Heart or cardiovascular disease ? High blood pressure? Abnormal bleeding? Stroke? Allergies to medicines or drugs? If yes, what? Sinus trouble? Asthma or hay fever? Fainting spells or seizures? Diabetes? Hepatitis, jaundice or liver disease? Aids or HIV Infection? Thyroid problems?		YES NO Respiratory problems, emphysema or bronchitis? Kidney trouble? Tuberculosis? Sexually transmitted disease? Epilepsy or other neurological disease? Cancer? Explain Radiation treatments for cancer, tumors or growths? Problems with previous dental treatment? Allergic to penicillin or codeine? Pregnant or nursing? (circle one) Are you taking birth control pills? Do you grind your teeth at night? Are you interested in whitening your teeth? Do you have any other health concerns not mentioned? List any drugs you are presently taking:		
Name and phone number of you IN CASE OF AN EMERGENCY Please Notify Name		Phone	Relationship :	
I UNDERSTAND THAT THE INFOR THAT IT WILL BE HELD IN THE ST MEDICAL STATUS. I AUTHORIZE THIS OFFICE TO VE DISCRETION OF THIS OFFICE, TO IF THIS OFFICE ACCEPTS INSUR. ME AND I ASSIGN ANY AND ALL TRENDERED AND AM ALSO RESPORT OF ANY ATTORNEY'S FEES AND CHARGED INTEREST AT THE RAT	MATION THAT I HAVE GIVEN (INCLUDIN RICTEST OF CONFIDENCE AND IT IS MY RIFY MY AND MY SPOUSE'S CREDIT ST. USE THE SERVICE OD ONE OR MORE ANCE, I AUTHORIZE PAYMENT DIRECTL' THE BENEFITS TO THIS OFFICE, AND I U DINSIBLE FOR PAYING ANY CO-PAYMEN' NDERTAKEN DUE TO MY FAILURETO PA	ENTATIONS G MY MEDICAL HISTORY) IS IT RESPONSIBILITY TO INFOR ATUS PRIOR TO EXTENDING CREDIT REPORTING SERVIC Y TO THIS OFFICE OF ANY IN NDERSTAND THAT I AM RESE T AND DEDUCTIBLES THAT M AY ANY AND ALL THE FEES TI ITH SUCH COLLECTION EFFO ANDING BALANCE (or the max	CORRECT TO THE BEST OF MY KNOWLEDGE, M TO THIS OFFICE OF ANY CHANGES IN MY CREDIT FOR TREATMENT AND AT THE ES. SURANCE BENEFITS OTHERWISE PAYABLE TO PONSIBLE FOR PAYMENT FOR SERVICES IY INSURANCE DOES NOT COVER. O THIS OFFICE, I AGREE TO BE RESPONSIBLE DORTS. I ALSO UNDERSTAND THAT I WILL BE	
Patient Signiture ((Parent's Signature if Minor)		Date	

