

**INSURANCE INFO**

**ABOUT YOU**

Today's Date: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ (First) \_\_\_\_\_ (Last) \_\_\_\_\_ (MI)

What You Prefer To Be Called: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Birth date: \_\_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_ / \_\_\_\_\_

Mailing Address: \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Primary Dental Insurance Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

Phone #: \_\_\_\_\_

Insured's SS #: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

**DENTAL INFORMATION**

Reason for today's visit: Exam \_\_\_ Emergency \_\_\_ Consultation \_\_\_

Are you in pain? Yes \_\_\_ No \_\_\_ How long? \_\_\_\_\_

Please, indicate any of the following problems: ( v )

Discomfort, clicking or popping in the jaw \_\_\_\_\_

Red, swollen or bleeding gums \_\_\_\_\_

Sensitive tooth, teeth or gums \_\_\_\_\_

Blisters/Sores in or around the mouth \_\_\_\_\_

Lost/Broken Fillings \_\_\_\_\_

Teeth Grinding \_\_\_\_\_

Ringling in Ears \_\_\_\_\_

Broken/Chipped Tooth \_\_\_\_\_

Stained Teeth \_\_\_\_\_

Locking Jaw \_\_\_\_\_

Bad Breath \_\_\_\_\_

Other: \_\_\_\_\_

Do You require pre-medication? Yes \_\_\_ No \_\_\_ Don't know \_\_\_

**We value your time and as such we appreciate your compliance with our 48 hour cancellation policy. Please be aware the 48 hour cancellation fee is \$150. Please know we will opt to use the credit card on file to process this fee.**

**MEDICAL HISTORY**

Are you taking any of the following medications?

Nerve pills \_\_\_

Pain killers (including aspirin) \_\_\_

Muscle relaxers \_\_\_

Stimulants \_\_\_

Blood Thinners \_\_\_

Tranquilizers \_\_\_

Insulin \_\_\_

Other(s), \_\_\_\_\_

Please, list any other surgeries or medical conditions you have or ever had: \_\_\_\_\_

Are you allergic to any of the following?

Latex \_\_\_ Penicillin/Amoxicillin \_\_\_ Tetracycline \_\_\_ Aspirin \_\_\_ Dental Anesthetics \_\_\_  
Others \_\_\_

Do you use tobacco? No \_\_\_ Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

Please, rate your general health from 1-10: \_\_\_\_\_

Do you wear contact lenses? Yes \_\_\_ No \_\_\_

Have you ever taken the drug Phen-fen and/or Redux? Yes \_\_\_ No \_\_\_

**For women:** Are you taking Birth Control pills? Yes \_\_\_ No \_\_\_ How many children have you had? \_\_\_\_\_

Are you pregnant? No \_\_\_ Yes \_\_\_ Are you nursing? Yes \_\_\_ No \_\_\_

**Do you have or have you had any of the following diseases, medical conditions or procedures? PLEASE CIRCLE Y (YES) OR N(NO)**

- |     |                         |     |                         |     |                            |
|-----|-------------------------|-----|-------------------------|-----|----------------------------|
| Y N | Heart Attack/Stroke     | Y N | Thyroid Problems        | Y N | Cancer/Tumors              |
| Y N | Heart Surgery/Pacemaker | Y N | Kidney Problems         | Y N | Shingles                   |
| Y N | Heart Murmur            | Y N | Liver problems          | Y N | Hepatitis                  |
| Y N | Rheumatic Fever         | Y N | Respiratory Problems    | Y N | HIV+/AIDS/ARC              |
| Y N | Mitral Valve Prolapse   | Y N | Sinus problems          | Y N | Arthritis/Rheumatism       |
| Y N | Artificial Valves       | Y N | Stomach Problems/Ulcers | Y N | Artificial Bones/Joints    |
| Y N | Heart Disease           | Y N | Psychiatric Problems    | Y N | Emphysema                  |
| Y N | Congenital Heart Defect | Y N | Venereal Problems       | Y N | Fainting/Seizures/Epilepsy |
| Y N | Chest pains             | Y N | Alcohol/Drug Abuse      | Y N | Severe/Frequent Headaches  |
| Y N | Scarlet Fever           | Y N | Tuberculosis TB         | Y N | Frequent Neck Pain         |
| Y N | Nervousness             | Y N | Jaw Problems TMJ/TMD    | Y N | Back Problems              |
- 
- |     |                           |     |                         |
|-----|---------------------------|-----|-------------------------|
| Y N | Cosmetic Surgery          | Y N | Leukemia                |
| Y N | X-Ray or Cobalt Treatment | Y N | Anemia                  |
| Y N | Chemotherapy              | Y N | High/Low Blood Pressure |
| Y N | Asthma                    | Y N | Bleeding Problems       |
| Y N | Difficulty Breathing      | Y N | Glaucoma                |
| Y N | Diabetes/Hypoglycemia     |     |                         |

Please read this as we wish to have a transparent relationship with our patients. Please note that a \$25 charge will be posted to your account at every office visit. Please note that payment is expected at the time of service, unless other arrangements have been made for treatments only: not diagnostics- examinations and x-rays. As a Fee For Service practice we will process your insurance information and will provide you a claim to submit to your insurance plan. If you have not received payment within 2-3 weeks, please contact your insurance company. We are here to assist you in obtaining reimbursement according to your insurance policy. You may contact us by telephone or email, whichever is convenient. As our patient we are available 24 hours for emergency treatment. Please note there is a \$395 additional charge for after hours emergency treatments. In case of an emergency which relates to oral and dental health Dr. Claudia Cotca is available to meet you at the Hospital. All fees apply.

I authorize Dr. Cotca and the Staff to perform any necessary services needed during diagnosis and treatment. I authorize provider to release information required to process insurance claims. I authorize Dr. Cotca and staff to contact my other medical and dental providers to obtain access to and discuss any related medical history information with past, current and future providers. My physicians and their contact information follows:

\_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_ Updates \_\_\_\_\_

DATE	INITIALS	PATIENT	MED HISTORY	CHANGE	DR. SIGNATUR	ADDRESS	UPDATE / INSURANCE	UPDATE

**Washington Institute Dentistry & Laser Surgery 202.997.4689 Dr. Claudia C. Cotca, DDS, MPH**