

Sophia Karabatsos Martz, D.M.D., P.C.  
66 Summer Street Manchester-by-the-Sea

We are pleased to welcome you to our Dental practice. Please take a few moments to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We truly look forward to working with you to maintain your dental health.

Patient Information

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Home Phone: \_\_\_\_ ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ .  
Name: \_\_\_\_\_ Social Sec. # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ .  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_  
Sex:  M  F Age: \_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Single  Married  Widowed  Divorced  
Patient Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone: \_\_\_\_ ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ .  
Whom May We Thank for Referring You ? \_\_\_\_\_  
In Case of Emergency who should be notified ? \_\_\_\_\_ Phone: \_\_\_\_ ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ .

Primary Insurance

Person Responsible For Account: \_\_\_\_\_ Home Phone: \_\_\_\_ ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ .  
Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Sec. # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ .  
Address: (if Different From Patient's) \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_  
Person Responsible Employed By: \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone: \_\_\_\_ ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ .  
Insurance Company ? \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of Other Dependent Covered Under This Plan \_\_\_\_\_

Additional Insurance

Is Patient Covered By Additional Insurance?  Y  N  
Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ .  
Address: (if Different From Patient's) \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_  
Subscriber Employed By: \_\_\_\_\_ Business Phone: \_\_\_\_ ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ .  
Insurance Company ? \_\_\_\_\_ Social Sec. # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ .  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of Other Dependent Covered Under This Plan \_\_\_\_\_

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Dental History

Reason For Today's Visit: \_\_\_\_\_

Former Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Last Dental Care: \_\_\_ / \_\_\_ / \_\_\_ .

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding Teeth                 | <input type="checkbox"/> Sensitivity To Hot      |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity To Sweets   |
| <input type="checkbox"/> Clicking Or Popping Jaw       | <input type="checkbox"/> Periodontal Treatment          | <input type="checkbox"/> Sensitivity When Biting |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Sores Or Growths In Your Mouth | <input type="checkbox"/> Sensitivity To Cold     |

How Often Do You Brush ? \_\_\_\_\_ How Often Do You Floss ? \_\_\_\_\_

Medical History

Physician's Name: \_\_\_\_\_ Date of Last Visit: \_\_\_ / \_\_\_ / \_\_\_ .

Have You had any serious illness or operations?  Yes  No If Yes, Describe: \_\_\_\_\_

Have You ever had a blood transfusion?  Yes  No If Yes, give approx. dates : \_\_\_\_\_

(Women) Are You Pregnant?  Yes  No Nursing ?  Yes  No Taking Birth Control Pills ?  Yes  No

Check ( ✓ ) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | describe _____                                | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |

MEDICATIONS

ALLERGIES

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Authorization

I Authorize my Insurance Company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signatures \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment unless prior arrangements have been approved.**