**JOHN B. MOCZYGEMBA, D.D.S.**
NEW BRAUNFELS COSMETIC DENTISTRY
AMERICAN ACADEMY OF GENERAL DENTISTRY, COSMETIC DENTISTRY, LASER DENTISTRY
HOURS: MON - THURS 8:00 AM - 5:00 PM
PHONE/FAX (830) 625-4515

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please don't hesitate to call us.

## PATIENT INFORMATION

Patient's Last Name _____ First _____ Initial _____ Preferred Name _____

SS # _____ Sex M F Marital Status S M W D O Birthdate ____/____/____ Age _____

Street Address _____ City _____ State _____ Zip Code _____

Email Address _____

Patient's Employer _____ Occupation (Indicate if student) _____

Employer's Street Address _____ City _____ State _____ Zip Code _____

Referred By (Name) _____ Family Physician (Name) _____

☐ Friend / Family ☐ Doctor ☐ Insurance Co. ☐ Other _____

## PHONE NUMBERS

Home _____ Work _____ Ext. _____ Cell _____ Spouse's Work _____

Best time and place to reach you _____

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

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

## ADDITIONAL INFORMATION

| | | | |
|---|---|---|---|
| Spouse's / Partner's Name | SS # | | Birthdate / / |
| Spouse's / Partner's Employer | Occupations (Indicate if student) | | Bus. Phone # |
| If Patient is a Minor, Please Complete<br>Mother<br>SS # | Birthdate / / | Employed By | Bus. Phone # |
| Father<br>SS # | Birthdate / / | Employed By | Bus. Phone # |

## DENTAL INSURANCE INFORMATION

Primary Insurance Name and Address of Company _____ Effective Date _____ Phone # _____

SS # OR ID # _____ Subscriber _____ Group Name and Phone # _____

Secondary Insurance Name and Address of Company _____ Effective Date _____ Phone # _____

SS # OR ID # _____ Subscriber _____ Group Name and Phone # _____

## DENTAL HISTORY

Reason for today's visit _____ Former Dentist _____

City/State _____ Date of last dental visit _____ Date of last dental x-rays _____

Circle any of the following you have had or presently have:

Bad taste
Bad breath
Bleeding gums
Blisters on lips or mouth
Burning sensation on tongue
Chew on one side of mouth
Cigarette, pipe or cigar smoking
Clicking or popping jaw
Dark or unsightly teeth
Dry mouth
Fingernail biting
Food collection between teeth
Grinding teeth
Gums swollen or tender
Jaw pain or tiredness
Lip or cheek biting
Loose teeth or broken fillings
Mouth breathing
Mouth pain, brushing
Orthodontic treatment
Periodontal treatment
Sensitivity to cold
Sensitivity to heat
Sensitivity to sweets
Sensitivity when biting
Sores or growths in your mouth

How often do you brush? _____

If you had a magic wand, what would you change about your teeth? _____ How often do you floss? _____

## HEALTH HISTORY

Physician's Name _____ Phone # _____ Date of last visit _____

**CIRCLE** any of the following you have had or presently have:

Autoimmune disorders
Anemia
Arthritis, Rheumatism
Asthma
Back Problems
Bleeding abnormally with extractions or surgery
Blood Disease
Cancer
Chemical Dependency
Chemotherapy
Circulatory Problems
Congenital Heart Lesions
Cortisone Treatments
Cough, persistent or bloody
Diabetes
Drug use (illegal)
Emphysema
Epilepsy
Excessive daytime sleepiness
Fainting or dizziness
Glaucoma
Headaches
Heart Problems
Hepatitis
Type _____
Herpes
High / Low Blood Pressure
HIV Positive
Jaundice
Jaw Pain
Kidney Disease
Liver Disease
Nervous Problems
Women:
Pregnant?
Due date
Nursing? _____
Pacemaker
Psychiatric Care
Radiation Treatment
Respiratory Disease
Scarlet Fever
Shortness of Breath
Sinus Trouble
Skin Rash
Snoring and/or Sleep Apnea
Special Diet
Stroke
Swelling of Feet or Ankles
Swollen Neck
Thyroid Problems
Tonsillitis
Tuberculosis
Tumor or growth on head or neck
Ulcer
Venereal Disease
Weight Gain or Loss, unexplained
Artificial Heart Valves
**ARTIFICIAL JOINTS/PROSTHESIS**
Heart Murmur
Mitral Valve Prolapse
Pre-Med Before dental appt.
Rheumatic Fever

## MEDICATIONS

List medication you are currently taking _____

_____

Pharmacy Name _____ Phone # _____

## ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Other _____
☐ Fluoride
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Latex

## AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED

I certify that I have read and understand the above information to the best of my knowledge. I understand that incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If I do not pay the balance within 25 days of the billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current will result in you being unable to provide additional services. I understand that I will be charged for missed appointment if 24 hour notice is not given.

X _____ Date _____

Signature of patient (or parent if minor)