Allan P. Capinpin, D.D.S.

PATIENT INFORMATION

Today's Date_____ (Please check in the box next to the best way(s) to reach you)

Name_____ ☐Home Phone( )_____

Address_____ ☐Cell Phone ( ) _____

_____ ☐ E-mail_____

City State Zip ☐ Email & Text is ok

Gender ☐Male ☐Female

Birth date_____/_____/_____ Age_____

☐Single ☐*Married ☐Widowed ☐Divorced

Employer_____

Employer Phone ( )_____

*INFORMATION ABOUT YOUR SPOUSE

Name_____

Birth date_____/_____/_____

Employer_____

Employer Phone ( )_____

As a courtesy service to our patients, we will bill your insurance company, as long as you have provided all necessary information. Your insurance policy is a contract between you, your employer and the insurance company. Insurance policies vary and services provided may not be covered. We cannot guarantee insurance payment, as the insurance carrier will not guarantee payment before a claim is received. Please contact your employer or insurance carrier if you have questions about your policy coverage.

PRIMARY CARRIER

(Self, unless you do not have your own coverage)

Name of Insured_____

Relationship _____

Birthdate_____

Insurance Company_____

ID/Social Security #_____

SECONDARY CARRIER

(Spouse, if you have your own coverage)

Name of Insured_____

Relationship _____

Birthdate_____

Insurance Company_____

ID/Social Security#_____

I, the undersigned certify that I(or my dependant) have insurance coverage with _____and assign directly to **Dr. Capinpin** 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 Dr. Capinpin to release all information necessary to secure the payment of benefits; I authorize the use of this signature on all insurance submissions. _____ _____ _____

Signature Date Relationship (to subscriber)

GENERAL INFORMATION

Whom may we thank for referring you?_____ Relationship: _____

Are you available for appointment on short notice?_____

Contact in case of an emergency:_____ Phone_____

CONSENT FOR DENTAL TREATMENT

I hereby give consent to any advisable and necessary dental procedures, medications, anesthetics or necessary radiographs (x-rays), to be administered by Dr. Allan Capinpin or the supervised licensed staff for diagnosis and treatment of my dental condition.

_____ _____

Patient/Guardian Signature Date

(Continued on back)

Patients Name:

MEDICAL HISTORY

Physician's Name_____ **Medical ID#**_____ **Phone ( )**_____
Have you been under the care of a medical doctor during the past two years? ..... Yes No
If yes, for what_____
Have you been a patient in the hospital during the past five years? ..... Yes No
If yes, for what_____

Due to constant changes in the medical and dental health fields it is very important of Dr. Capinpin to know about your over all health. **Please circle "yes" or "no" if you have or have had any of the following:**

yes no **Anemia**
yes no **Angina Pectoris**
yes no **Arthritis/Rheumatism**
yes no **Artificial Heart Valve**
yes no **Artificial Joints (hip, knee)**
yes no **Asthma**
yes no **BRONJ**
yes no **Back Problems**
yes no **Blood Transfusion**
yes no **Bruise Easily**
yes no **Cancer/ Chemotherapy**
yes no **Chronic Cough**
yes no **Cold Sores/Fever Blisters**
yes no **Congenital Heart Defect**
yes no **Contact Lens**
yes no **Cortisone Treatments**
yes no **Diabetes**
yes no **Diet (special, restricted)**
yes no **Eating Disorders**
yes no **Emphysema**
yes no **Epilepsy/Seizures**
yes no **Fainting/Dizzy Spells**
yes no **Glaucoma**
yes no **HIV/AIDS**
yes no **Hay Fever**
yes no **Headaches (Frequent)**
yes no **Heart Attack**
yes no **Heart Surgery**
yes no **Hemophilia**
yes no **Hepatitis (A,B,C)**
yes no **High Blood Pressure**
yes no **High Cholesterol**
yes no **Kidney Trouble**
yes no **Liver Disease**
yes no **Nervous/Anxious**
yes no **Pacemaker**
yes no **Psychiatric Care**
yes no **Radiation Therapy**
yes no **S.T.D.**
yes no **Sickle Cell Disease**
yes no **Sinus Trouble**
yes no **Stroke**
yes no **Thyroid (high, low)**
yes no **Tuberculosis**
yes no **Ulcers**
yes no **Yellow Jaundice**

Any other conditions not listed? _____

MEDICATIONS

List medications you are currently taking and its uses _____

_____

_____

List herbal remedies or vitamins you take _____

ALLERGIES

Are you aware of having an allergic (or adverse reaction) to any medications or substance? _____
If yes, please list _____

Have you ever had IV Bisphosphonate Therapy? ..... Yes No
Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? ***These include combinations of Ionimin/Adipex/ Fastin(brand name for phentermine), Pondimin (fenfluramine),and Redux (dexfenfluramine)*****..... Yes No**
Have you lost or gained more than 10 pounds in the past year? ..... Yes No
Have you ever been tested for a sleep disorder?..... Yes No
Do you smoke or use other tobacco products..... Yes No

WOMEN

Are you: Pregnant? .....Yes (months_____) Nursing? ..... Yes No
Taking Birth control Pills? ..... Yes No
Using oral Bisphosphonate for Hormone Replacement Therapy (Fosamax,Actonel,Boniva)?... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all questions to the best of my knowledge and I understand that it is my responsibility to inform the doctor if I ever have a change in health or medication.

_____ _____
Patient/Guardian Signature **Date**

Dr. Capinpin has reviewed the above health history with the patient. _____
Signature **Date**