Paul D. Nagode, DDS, PC
BEAUTIFUL, HEALTHY SMILES ARE OUR BUSINESS!

Welcome

Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we are happy to help!

To the office of Paul Nagode, DDS

Date ____________

Patient Information (Confidential)

SS# ________________

Name ____________________ Birthdate ____________ Home Phone ____________
Address ____________________ City ____________ State ______ Zip ________
Email ____________________ Cell Phone ____________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School / College ____________________ State ______ ☐ Full Time ☐ Part Time
Patient's or Parent/Guardian's Employer ____________________ Work Phone ____________
Business Address ____________________ City ____________ State ______ Zip ________
Spouse or Parent/Guardian ____________ Employer ____________ Work Phone ____________
Whom May We Thank for Referring You? ____________________
Person to Contact in Case of Emergency ____________________ Phone ____________

Responsible Party

Person Responsible for this Account ____________________ Relationship to Patient ____________
Address ____________________ Home Phone ____________
Email ____________________ Cell Phone ____________
Driver's License # ____________ Birthdate ____________ Financial Institution ____________
Employer ____________________ Work Phone ____________ SSN ____________
Is this Person currently a Patient in our Office? ☐ Yes ☐ No
We offer the following methods of payment. Please check the option you prefer to pay in full at each appointment:
☐ Cash ☐ Personal Check ☐ Visa, Mastercard, Discover, AmEx ☐ ☐ CareCredit

Insurance Information (Dental Coverage)

Name of Insured ____________________ Relationship to Patient ____________
Birthdate ____________ SSN ____________ Date Employed ____________
Name of Employer ____________________ Work Phone ____________
Employer Address ____________________ City ____________ State ______ Zip ________
Insurance Company ____________________ Group# ____________ ID: ____________
Claims Mailing Address ____________________ City ____________ State ______ Zip ________
Annual Benefit ____________ Deductible ________ How Much Has Been Used This Year? ________

Office Policies

Please be prompt for appointments. Arriving late reduces the time we will have to spend with you. Appointments changed with less than 24 hrs. notice are subject to a broken appointment fee.

While we will file your insurance as a courtesy, payment for services are due at the time treatment is rendered. It is the patient's responsibility to be familiar with their policy and to pay deductibles, co-pays and non-covered charges at the time of the visit. Overdue charges shall bear interest at the rate of 1.5% per month (18% annually) from the date charges are rendered until paid. The patient shall pay all costs of collection including reasonable amount for attorney's fees.

This is to certify that I, the undersigned, authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my dependent 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 any insurance benefits otherwise payable to me and understand that my dental insurance may pay less than the actual bill for services. I have read and understand the above Office Policies and agree to be responsible for payment of all services rendered on my behalf or my dependents.

Initials ______

OVER ➡

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Patient Medical History

Physician ________________________ Office phone ________________ Date of Last Exam ________________

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
3. Are you taking any prescription, OTC medications or health supplements? List:________________________	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hrs?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

9. Are you allergic to or had any reactions to:	YES	NO
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or other Antibiotics?	☐	☐
Sulfa Drugs	☐	☐
Sedatives	☐	☐
Aspirin	☐	☐
Any Metals (e.g. Nickel, Mercury, etc)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐

10. WOMEN ONLY:	YES	NO
a) Are you pregnant or could be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

11. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
Acid Reflux	☐	☐	Excessive Thirst	☐	☐	Lung Disease	☐	☐
AIDS/HIV positive	☐	☐	Fainting/Dizziness	☐	☐	Mitral Valve Prolapse	☐	☐
Alzheimer's Disease	☐	☐	Frequent Cough	☐	☐	Osteoporosis	☐	☐
Anaphylaxis	☐	☐	Frequent Headaches	☐	☐	Pain in Jaw Joints	☐	☐
Anemia	☐	☐	Genital Herpes	☐	☐	Psychiatric Care	☐	☐
Angina	☐	☐	Glaucoma	☐	☐	Radiation Treatments	☐	☐
Arthritis/Gout	☐	☐	Heart Attack/Failure	☐	☐	Recent Weight Loss	☐	☐
Artificial Heart Valve	☐	☐	Heart Murmur	☐	☐	Renal Dialysis	☐	☐
Artificial Joint	☐	☐	Heart Pacemaker	☐	☐	Rheumatic Fever	☐	☐
Asthma/Breathing Problems	☐	☐	Heart Trouble/Disease	☐	☐	Rheumatism	☐	☐
Blood Disease	☐	☐	Hemophilia	☐	☐	Scarlet Fever	☐	☐
Blood Transfusion	☐	☐	Hepatitis A	☐	☐	Shingles	☐	☐
Cancer	☐	☐	Hepatitis B or C	☐	☐	Sickle Cell Disease	☐	☐
Chemotherapy	☐	☐	Herpes	☐	☐	Sinus Trouble	☐	☐
Chest Pains	☐	☐	High Blood Pressure	☐	☐	Sleep Apnea	☐	☐
Cold Sores/Fever Blisters	☐	☐	High Cholesterol	☐	☐	Stomach/Intestinal Disease	☐	☐
Congenital Heart Disease	☐	☐	Hypoglycemia	☐	☐	Stroke	☐	☐
Convulsions	☐	☐	Irregular Heartbeat	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Jaundice	☐	☐	Tuberculosis	☐	☐
Drug Addition	☐	☐	Kidney Problems	☐	☐	Tumors or Growths	☐	☐
Emphysema	☐	☐	Leukemia	☐	☐	Ulcers	☐	☐
Epilepsy or Seizures	☐	☐	Liver Disease	☐	☐	Venereal Disease	☐	☐

DENTAL HISTORY:

Last Dentist & Location: ________________________________ Date of Last Visit: ________________

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever had any of the following jaw problems?	☐	☐
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty opening, closing or chewing	☐	☐

	YES	NO
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you had any difficult extractions or Prolonged bleeding following extractions?	☐	☐
12. Do you snore or breathe through your mouth?	☐	☐
13. Have you had orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
15. Have you had instructions for teeth/gum care?	☐	☐
16. Do you like your smile?	☐	☐

I, the undersigned, certify that I have read and understand the above information & have answered accurately. I authorize the doctor & staff to take x-rays, photos or other aids to make a thorough diagnosis of dental needs with the use of local anesthetic as indicated.

SIGNATURE:____ DATE:____________________

Patient (or parent/guardian if minor)

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