Welcome to Andrew Katerakis DDS!

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

Name _____ Home Phone _____ Cell Phone _____

Address _____City _____State _____ Zip _____

Social Security Number _____Birth Date _____Email_____

Preferred Method of appointment confirmation: __Text __Email __Phone Call

Check Appropriate Status: __Minor __Single __Married __Widowed

Patient's or Parent's Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____Phone:_____

Dental Insurance Information
Please provide a copy of your dental insurance card to our office team.

Subscriber's name: _____ Date of birth: _____

Subscriber's employer: _____ Member ID: _____

Medical History
Medical Doctor: _____ Phone Number: _____

Have you ever had any of the following? Please check those that apply:

□Aids/HIV	□Cardiac Bypass	□High Blood Pressure	□Stroke
□Artificial Heart Valve	□Chronic Headache	□Mitral Valve Prolapse	□Tobacco Use
□Artificial Joints	□Circulatory Problems	□Multiple Sclerosis	□Tuberculosis
(Date: _____)	□Diabetes	□Pacemaker/Defibrillator	□Venereal Disease
□Asthma	□Epilepsy	□Previous Endocarditis	Other _____
□Autoimmune Disease	□Heart Disease/Stent	□Respiratory Disease	_____
□Cancer	□Hepatitis	□Rheumatic Fever	

(Women Only) Are you pregnant? _____ Are you Taking Birth Control pills? _____

***Medications:** List any that you are taking:

_____
_____
_____
_____
_____

**Inform the doctor if you are taking a type of drug called a bisphosphonate.*

***Allergies:** List any medications, metals, latex, anesthetics, etc.

_____
_____
_____
_____
_____
_____

*****The above information is accurate and complete to the best of my knowledge and is only for use in treatment or for billing and processing of insurance for benefits for which I am entitled. I acknowledge financial responsibility for charges incurred and allow my insurance, if any, to pay directly to Andrew Katerakis DDS.

*Any appointment cancelation or no-show within 24 hours of your scheduled time may be subject to a $50 fee.

*Any unconfirmed appointments, within 24 hours of appointment, may be subject to cancelation at the office's discretion.

***Signature** _____ ***Date** _____
Patient or Parent/Guardian (If Minor)