Andrew Katerakis DDS

WELCOME TO OUR DENTAL PRACTICE!

MEDICAL HISTORY

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: _____

Name of insurance company: _____

Medical History

Medical Doctor: _____ Phone Number: _____

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

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

(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.

_____
_____
_____
_____
_____

***Power of attorney documentation must be provided, if applicable.**

*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 cancellation or no-show within 48 hours of your scheduled time may be subject to a $50 fee.

*Any unconfirmed appointments, within 48 hours of appointment, may be subject to cancellation at the office's discretion.

***Signature** _____ ***Date** _____

Patient or Parent/Guardian (If Minor)