Welcome to Stewart A. Moss and Associates D.D.S., P.C.

Our primary goal is to provide you with the highest quality care and make your experience here positive.

For your information:

· Full payment is required at time of service

· We accept checks and all major credit cards

· We have interest free financing available

· A complete treatment plan will be presented for your acceptance prior to receiving treatment

· We will only file insurance claims as a courtesy and at your request

· A 24 hour notice is appreciated for all cancelled appointments; **A minimum of $35.00 will be charged**

· If you are more than 15 minutes late for your scheduled appointment the appointment will be reschedule for a later date; **A minimum of $35 will be charged**

Patient Signature: ______________________________ Date: ______________

Welcome to Stewart A. Moss and Associates D.D.S., P.C.

Today's Date: _______________ www.alphadentalnorth.com

Patient Information:

Last Name_____________________________ First Name ___________________ M.I. ______

Address ____ City _____________________

State ______ Zip ____________ Single____ Married____ DOB __________________________

Social Security # ___________________ E- Mail _____________________________________

Home # ____________________ Cell # ___________________ Work # _________________

Dental Insurance Company: _____________________________ Phone # ________________

Subscriber Name ____________________________ Relationship to Patient _______________

Policy # ___________________________________ Group # ____________________________

Subscriber DOB ______________ SS# ____________________ Sex _________

Who does policy cover? Spouse ________ Children _________ Both __________

About Your Family:

Name	Birth Date	Relationship

Other Dental Insurance: ____________________________ Phone# _____________________

Subscriber Name __________________________ Relationship to Patient ________________

Policy # __________________________________ Group # ____________________________

PLEASE HAVE DENTAL INSURANCE CARDS AVAILABLE TO HAND TO THE RECEPTIONIST; IF YOU ARE A NEW PATIENT AND DO NOT HAVE YOUR INSURANCE CARDS WE WILL HAVE TO RESCHEDULE YOUR APPOINTMENT

Welcome to Stewart A. Moss and Associates D.D.S., P.C.

Health History:

Patient Name: ______________________________

It is important that we know about your medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission.

Physician's Name ______________________________ Phone # ______________

In case of emergency, notify ______________________________ Phone # ______________

Do you have, or have you had any of the following? Please mark with an X both yes and no indication yes you have or no you have not had the following listed below.

Yes	No	
___	___	Heart Problems
___	___	Heart Murmur
___	___	High Blood Pressure
___	___	Low Blood Pressure
___	___	Circulatory Problems
___	___	Stroke
___	___	Pacemaker
___	___	Bleeding Problems
___	___	Anemia
___	___	Nervous System/ Problems ______________
___	___	Smoke/ Chew Tobacco
___	___	Scarlet Fever
___	___	Tonsillitis
___	___	Tuberculosis
___	___	Arthritis
___	___	Asthma
___	___	Typhoid Fever
___	___	Diabetes
___	___	Ulcer
___	___	Hepatitis A or B

Yes	No	
___	___	M.S./ M.D./ Cerebral Palsy
___	___	Epilepsy
___	___	Hemophilia
___	___	Allergies to Medication
	If yes, allergic to	______________ ______________
___	___	Allergies to Anesthetics
___	___	Measles
___	___	Mumps
___	___	Rheumatic Fever
___	___	Positive HIV (AIDS)
___	___	AIDS
___	___	Blood Transfusion
	dates:	______________
___	___	Artificial Joints
___	___	Malignances
___	___	Sinus Problems
___	___	Psychiatric Care
___	___	STD
___	___	Are you Pregnant?

Explanation of Above: ______________________________

____

Medications: List medications you are taking (or within the past 30 days. Prescribed or over-the counter. i.e. Antibiotics, Birth Control, Aspirin, etc.)______________

Are you currently under the care of a physician? Yes___ No ___ Explain: ______________

Have you been hospitalized for any reason in the past 5 yrs? Yes___ No ___ Explain: ______________

When was the last time you were at the dentist? _______ Why did you leave? ______________

Have you had any problems with previous dental treatment? Yes___ No ___ Explain: ______________

When was the last time you had a cleaning? __________ How long have you had dental insurance? ___

Whom may we thank for referring you? ______________________________

Signature: ______________________________ Date: ______________

Dentist Notes and History Update: ______________________________