Sophia Karabatsos Martz, D.M.D., P.C.
66 Summer Street Manchester-by-the-Sea

We are pleased to welcome you to our Dental practice. Please take a few moments to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We truly look forward to working with you to maintain your dental health.

Patient Information

Today's Date: ____/____/____ Home Phone: ___(____)____-____.
Name: _____ Social Sec. # ____-____-____.
Address: _____
City: _____ State _____ Zip _____
Sex: ☐ M ☐ F Age: _____ Date of Birth: ___/___/___ ☐Single ☐Married ☐Widowed ☐Divorced
Patient Employed By: _____ Occupation: _____
Business Address _____ Business Phone: ___(____)____-____.
Whom May We Thank for Referring You ? _____
In Case of Emergency who should be notified ? _____ Phone: ___(____)____-____.

Primary Insurance

Person Responsible For Account: _____ Home Phone: ___(____)____-____.
Relationship to Patient: _____ Date of Birth:___/___/___ Social Sec. # ___-___-____.
Address: (if Different From Patient's) _____
City: _____ State _____ Zip _____
Person Responsible Employed By: _____ Occupation _____
Business Address _____ Business Phone: ___(____)____-____.
Insurance Company ?
Contract # _____ Group # _____ Subscriber # _____
Names of Other Dependent Covered Under This Plan _____

Additional Insurance

Is Patient Covered By Additional Insurance? ☐Y ☐N
Subscriber Name: _____ Relationship to Patient: _____ Date of Birth:___/___/___.
Address: (if Different From Patient's) _____
City: _____ State _____ Zip _____
Subscriber Employed By: _____ Business Phone: ___(____)____-____.
Insurance Company ? _____ Social Sec. # ___-___-____.
Contract # _____ Group # _____ Subscriber # _____
Names of Other Dependent Covered Under This Plan _____

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Dental History

Reason For Today's Visit:: _____

Former Dentist: _____

Address: _____

Date of Last Dental Care:___/____/__.

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity To Hot
☐ Bleeding Gums	☐ Loose Teeth or Broken Fillings	☐ Sensitivity To Sweets
☐ Clicking Or Popping Jaw	☐ Periodontal Treatment	☐ Sensitivity When Biting
☐ Food Collection Between Teeth	☐ Sores Or Growths In Your Mouth	☐ Sensitivity To Cold

How Often Do You Brush ? _____ How Often Do You Floss ? _____

Medical History

Physician's Name: _____ Date of Last Visit: ___/____/__.

Have You had any serious illness or operations? ☐ Yes ☐ No If Yes, Describe: _____

Have You ever had a blood transfusion? ☐ Yes ☐ No If Yes, give approx. dates : _____

(Women) Are You Pregnant? ☐ Yes ☐ No Nursing ? ☐ Yes ☐ No Taking Birth Control Pills ? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ HIV Positive	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	describe _____	☐ Radiation Treatment	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease

MEDICATIONS	ALLERGIES
_____	_____
_____	_____

Authorization

I Authorize my Insurance Company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signatures _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.