Drs. Zouhary & Fisher
DENTISTS

Dear New Patient,

We want to take a moment to express our delight that you have chosen to become a member of our dental family. We hope every visit with us is a pleasant one.

Our goal is to offer the highest quality of dentistry, with tender loving care extended in an environment where the physical and emotional, as well as spiritual well-being of our patient is taken into consideration.

If, at anytime, you have a concern or questions about your dental health, one of our dental health professionals is available to meet your needs. We appreciate your trust and confidence in our dental team, and we are looking forward to many years of service to you.

Sincerely,

Dr. William J. Zouhary
Dr. Timothy R. Fisher

Drs. Zouhary & Fisher, D.D.S., Inc.
Appointments: 419.666.3327 | Email: info@zfdentists.com
849 Dixie Highway | Rossford, Ohio 43460-1375

PATIENT INFORMATION

(CIRCLE ONE) DR. MR. MRS. MISS REV. MS.

NAME _____ NICKNAME _____

PHONE (HOME) _____ (WORK) _____ (CELL) _____

ADDRESS _____ SOCIAL SECURITY # _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SEX M/F _____ MARITAL STATUS (CIRCLE ONE) S M D W

OCCUPATION/STUDENT _____ EMPLOYER _____

SPOUSE'S NAME _____

PREVIOUS DENTIST _____ REFERRED BY _____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

ADDRESS _____ PHONE _____

MEDICAL HISTORY

DATE OF LAST PHYSICAL _____

NAME OF PHYSICIAN _____ PHARMACY NAME & PHONE _____

PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS.

		YES	NO
1.	DO YOU HAVE A CURRENT MEDICAL PROBLEM?		
2.	HAVE YOU TAKEN ANY MEDICATIONS IN THE LAST MONTH?		
3.	HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY MEDICATION, I.E. NOVACAINE, PENICILLIN?		
4.	ARE YOU ALLERGIC TO LATEX?		
5.	HAVE YOU HAD TEMPORAL MANIBULAR JOINT PROBLEM (TMJ)?		
6.	DO YOU HAVE ANY DENTAL (TEETH) IMPLANTS?		
7.	HAVE YOU EVER HAD A JOINT REPLACEMENT, I.E. KNEE, HIP?		
8.	DO YOU SNORE?		
9.	DO YOU HAVE PERSISTENT COUGHS OR BLOODY SPUTUM?		
10.	DO YOU SMOKE OR USE SNUFF?		
11.	DO YOU USE BIRTH CONTROL PILLS?		
12.	ARE YOU PREGNANT?		
13.	DO YOU HAVE NIGHT SWEATS?		
14.	ANY UNUSUAL WEIGHT LOSS?		
15.	HAVE YOU EVER BEEN EXPOSED TO OR TESTED POSITIVE FOR TB?		
16.	HAVE YOU BEEN TESTED FOR HIV? IF YES, CIRCLE: POSITIVE NEGATIVE		

		YES	NO
17.	CANCER?		
18.	CHEMOTHERAPY OR RADIATION?		
19.	LUNG TROUBLE, I.E. COPD OR ASTHMA?		
20.	HEPATITIS, LIVER DISEASE?		
21.	ARTHRITIS, YOU OR FAMILY?		
22.	DIABETES, YOU OR FAMILY?		
23.	EXCESSIVE BLEEDING?		
24.	SEXUALLY TRANSMITTED DISEASES?		
25.	SHORTNESS OF BREATH?		
26.	SWELLING OF ANKLES OR FEET?		
27.	ALCOHOL DEPENDENCY OR DRUG DEPENDENCY?		
28.	HEART ATTACK?		
29.	PACE MAKER/ARTIFICIAL HEART VALVE?		
30.	RHEUMATIC FEVER?		
31.	HEART MURMUR OR MITRAL VALVE?		
32.	BLOOD PRESSURE PROBLEM, I.E. HIGH OR LOW?		
33.	FAINTING SPELLS?		
34.	CONVULSIONS, EPILEPSY?		
35.	KIDNEY PROBLEMS?		
36.	IS THERE ANY OTHER MEDICAL INFORMATION WE SHOULD KNOW ABOUT YOU?		
37.	ARE YOU TAKING A BONE DENSITY DRUG FOR OSTEOPOROSIS LIKE **FOSAMAX**, **AREDIA**, **ACTONEL**, **ZOMETA**, OR **BONIVA**?		

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE SPECIFY THE NUMBER OF THE QUESTION AND GIVE DETAILS IN THE SPACE PROVIDED BELOW.

_____

_____

_____

(OVER) SIGNED **X** _____ DATE _____

REVISION DATE 10/08

FINANCIALLY RESPONSIBLE PARTY

NAME _____ DR. MR. MRS. MISS MS. REV.

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ EXT# _____

OCCUPATION _____ SOC. SEC. # _____

I UNDERSTAND THAT A FINANCE CHARGE OF 1% PER MONTH (12% PER YEAR) WILL BE ADDED TO MY ACCOUNT ON ANY BALANCE REMAINING OVER 90 DAYS OLD.

X _____
SIGNATURE

DENTAL INSURANCE INFORMATION

1. PRIMARY INSURANCE CO. NAME _____
2. PRIMARY EMPLOYER'S NAME _____
3. PRIMARY EMPLOYER'S PHONE _____
4. SUBSCRIBER S. S. # _____ BIRTHDATE _____
5. SECONDARY INSURANCE CO. NAME _____
6. SECONDARY EMPLOYER'S NAME _____
7. SECOND EMPLOYER'S PHONE _____
8. SUBSCRIBER S. S. # _____ BIRTHDATE _____

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTOR THE AMOUNT DUE ON MY CLAIM FOR SERVICES RENDERED TO ME OR MY DEPENDENT. I FURTHER AGREE THAT SHOULD THE AMOUNT BE INSUFFICIENT TO COVER THE ENTIRE MEDICAL AND SURGICAL EXPENSE, I WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE; AND IF THE NATURE OF THE DISABILITY BE SUCH THAT IT IS NOT COVERED BY THE POLICY, I WILL BE RESPONSIBLE TO THE DOCTOR FOR PAYMENT OF THE ENTIRE BILL.

SIGNED X _____ DATE _____

I understand that all broken appointments and appointments that are not cancelled 24 hours prior to time of appointment is subject to a broken appointment/late cancellation fee.

Signed X _____

Date _____