PATIENT INFORMATION FORM

Date _____

PERSONAL INFORMATION

Name _____
Last First Middle Initial Mr/Mrs/Ms/Dr

I prefer to be called _____ ❒ Male ❒ Female

Birthdate ___/___/___ SS # _____

Home address _____
Apt/Condo number

_____
City State Zip

Home phone _____ Cell # _____

❒ Single ❒ Married ❒ Domestic partner

Employer _____

Address _____
City State Zip

How long employed? _____ Occupation _____

Work # _____ Cell # _____

Spouse/Guardian/Domestic partner

His/her name _____

Employer _____

Birthdate ___/___/___ S/S # _____

In an emergency, whom should we contact?

_____

Previous/present dentist _____
(Circle one)

Address _____
City State Zip

PRIMARY DENTAL INSURANCE

Company name _____

Address _____
City State Zip

Telephone _____

Group # (plan, local, or policy) _____

Employer _____

Insured's name _____ Relation _____

Insured's birthdate: ___/___/___ Insured's S/S # _____

Insured's employer _____

SECONDARY DENTAL INSURANCE

Company name _____

Address _____

Telephone _____

Group # (plan, local, or policy) _____

Employer _____

Insured's name _____ Relation _____

Insured's birthdate: ___/___/___ Insured's S/S # _____

Insured's employer _____

Whom may we thank for referring you to us?

_____

DENTAL HEALTH INFORMATION

Please check one

Have you ever had any of the following?

❒ Orthodontic treatment
❒ Oral surgery
❒ Periodontal treatment
❒ Your teeth ground or bite adjusted
❒ A bite plate or other appliance
❒ C-PAP

❒ Yes ❒ No Have you noticed any loosening of your teeth?
❒ Yes ❒ No Does food become caught between your teeth?
❒ Yes ❒ No Do you suffer from pain and/or swelling of your gums?
❒ Yes ❒ No Do your gums often bleed when you brush your teeth?
❒ Yes ❒ No Do you have an unpleasant odor or bad taste in your mouth?
Reasons: ❒ Decay ❒ Gum disease ❒ Other _____
❒ Yes ❒ No Have missing teeth been replaced?
❒ Yes ❒ No Do you ever have any soreness, pain, clicking, or popping in the area in front of your ears?

If yes to the above, do you

❒ Clench or grind your teeth while awake or asleep?
❒ Bite your lips or cheeks regularly?
❒ Hold foreign objects with your teeth?
❒ Breath primarily through your mouth?

When did you last have your teeth cleaned? _____ How often did you see your dentist in the past? _____

When do you brush your teeth? _____ How often? _____ What do you use to clean your teeth? _____

Do you feel apprehensive when having treatment? ❒ Yes ❒ No
Does fear of pain make you postpone your dental treatment? ❒ Yes ❒ No

Is it important to keep your natural teeth? ❒ Yes ❒ No
Would you spend 15 minutes a day to keep your natural teeth? ❒ Yes ❒ No

Over

MEDICAL HISTORY

Dental disease is produced by a combination of many complex elements. The success of therapy is dependent upon the necessity of resolving every possible contributing factor. The following questions are all associated with the proper management of your oral health.

Name of your physician _____ Phone # _____ City _____

- ❒ Yes ❒ No Are you in good health?
- ❒ Yes ❒ No Do you smoke?
- ❒ Yes ❒ No Have you been a hospital patient during the past two years?
- ❒ Yes ❒ No Have you been under the care of a medical doctor during the past two years?
- ❒ Yes ❒ No Have you ever had any excessive bleeding requiring special treatment?
- ❒ Yes ❒ No Are you allergic to (i.e. itching, rash, swelling of hands feet, or eyes) or made sick by penicillin, aspirin, codeine, latex, or any other drugs or medications?

If so, which? _____

List any medications, homeopathic (herbs), vitamins, or supplements you are now taking regularly including birth control:

_____

Check any of the following you have had or have at present:

- ❒ Heart failure
- ❒ Heart disease
- ❒ Heart attack
- ❒ High blood pressure
- ❒ Heart murmur
- ❒ Heart valve implant
- ❒ Congenital heart lesions
- ❒ Heart pacemaker implant
- ❒ Heart surgery
- ❒ Artificial joint
- ❒ Sickle cell disease
- ❒ Mitral valve prolapse
- ❒ Epilepsy or seizures
- ❒ Psychiatric treatment
- ❒ Emphysema
- ❒ Bruise easily
- ❒ Tuberculosis
- ❒ Diabetes, Type 1
- ❒ Diabetes, Type 2
- ❒ Rheumatic fever
- ❒ Sinusitis
- ❒ Anemia
- ❒ Thyroid disease
- ❒ Cortisone medication
- ❒ Stroke
- ❒ Venereal disease
- ❒ Fainting or dizzy spells
- ❒ AIDS/HIV+
- ❒ Hepatitis A (infectious)
- ❒ Hepatitis B (serum)
- ❒ Hepatitis C
- ❒ Liver disease
- ❒ Scarlet fever
- ❒ Allergies/hives
- ❒ Latex allergy
- ❒ Glaucoma
- ❒ Pain in jaw joints
- ❒ Kidney disease
- ❒ Ulcers
- ❒ Nervousness
- ❒ Drug addiction
- ❒ Asthma
- ❒ Hay fever
- ❒ Blood transfusion
- ❒ Hemophilia
- ❒ Arthritis
- ❒ Rheumatism
- ❒ Cold sores
- ❒ Herpes
- ❒ Yellow jaundice
- ❒ Migraine headaches
- ❒ Chemotherapy
- ❒ X-ray or cobalt treatment

Do you have any diseases, conditions, or physical problems not listed above? If so, please list:

_____

- ❒ Yes ❒ No When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are tired?
- ❒ Yes ❒ No Do your ankles swell during the day?
- ❒ Yes ❒ No Do you snore or have sleep apnea? Do you wear a C-PAP?
- ❒ Yes ❒ No Have you lost or gained more than ten pounds in the past year?
- ❒ Yes ❒ No Do you ever wake up gasping for air?

Women

- ❒ Yes ❒ No Are you pregnant at this time?
- ❒ Yes ❒ No Do you anticipate becoming pregnant?
- ❒ Yes ❒ No Are you taking birth control pills?
- ❒ Yes ❒ No Are you prone to yeast infections?
- ❒ Yes ❒ No Have you begun peri menopause?
- ❒ Yes ❒ No Are you in menopause?
- ❒ Yes ❒ No Are you on hormone replacements?

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform this office at my next appointment.

It is Dr. Prepsky's policy to thoroughly explain all necessary dental treatment. Based on an understanding of the treatment, the undersigned hereby authorizes Dr. Prepsky and her staff to perform dental treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents entail certain risks.

Patient's Responsibility for Fees: I understand that responsibility for payment for dental services provided in this office for myself or my dependent is mine. If necessary, special arrangements can be made.

I understand that there will be a charge for any missed appointment without a 24-hour notice of cancellation.

If applicable, I hereby authorize the payment from any insurance company due me be paid directly to Devoree Prepsky, D.M.D. In the event of default of payment, patient or party responsible for fees agrees to pay any and all costs of suit, collection, and attorney's fees.

_____ _____

Patient's signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

10/4/10