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Cosmetic Reconstructive Dentistry

PATIENT HISTORY AND ACQUAINTANCE FORM

This Information is Important for Our Records and Your Health

Today's Date _____ Patients Name_____Email:_____

SSN _____ Date of Birth _____Age_____

Residence Address _____ City _____ State_____ Zip _____

Residence Phone _____ Work Phone _____Cell Phone _____

Employed By _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Referred By _____ Email: _____

Do you have any dental insurance? Y N Name of insurance company _____

Address of insurance company _____ Group No. _____

Name if insured party _____ Who will pay this account? _____

Marital Status Single Married Widowed Divorced Separated

NAME IN FULL OF YOUR (HUSBAND, WIFE, PARENT) _____ Date of Birth _____

Employed by _____ Employer's Address _____

Email :_____ Occupation:_____

SSN _____ Physician's name _____Phone Number _____

In case of emergency, who should we notify? _____Phone Number_____

	YES	NO
How long since your last dental visit? _____		
Do your gums bleed at all upon brushing/flossing? Y N _____		
Are you having any dental problems presently? ……	☐	☐
If so, describe _____		
Have you ever had periodontal (gum) treatments? ……	☐	☐
Are you interested in cosmetic dentistry (bleaching, etc.)? ……..	☐	☐
Have you ever had orthodontics (braces)? ……	☐	☐
Do you brush your teeth regularly? ……..	☐	☐
Do you floss your teeth regularly? ……	☐	☐
Do you grind or clench your teeth when you are nervous or sleeping? ……	☐	☐
Do your jaws click or pop when you chew? ……..	☐	☐
Is there any other information we should know about your health or previous dental visits? ……..	☐	☐
If so, explain _____		
Have I ever treated any of your friends or family? ……	☐	☐
If so, name? _____		
Have you ever been treated for TMJ (jaw) problems? ……..	☐	☐

I AUTHORIZE THE RELEASE OF ALL DENTAL INFORMATION ABOUT ME OR MY MINOR CHILDREN TO PHYSICIANS, HOSPITALS, INSURANCE COMPANIES AND DENTISTS.

SIGNATURE OF PATIENT (IF MINOR, PARENT SIGNS) _____DATE _____

TURN OVER AND CONTINUE……

	YES	NO
Your current physical health is ☐ good ☐ fair ☐ poor		
Has there been any significant events in your health during the last year? ……	☐	☐
Have you been examined or treated by your physician within the last year? If so, for what? ……	☐	☐
Are you taking any medications at this time? …….	☐	☐
If so, list them? _____		
Do you take aspirin on a regular basis? ……	☐	☐
Have you ever had a serious illness or operation? If so, what? _____	☐	☐
Did you have a blood transfusion from 1980 to 1985? ……	☐	☐
Have you been under treatment with either Fen-Phen or Redux? ……...	☐	☐

Have you ever had or been treated for any of the following diseases or conditions? …….

Y	N		Y	N		Y	N		Y	N	
☐	☐	Heart Attack	☐	☐	Chest Pain Upon Exertion	☐	☐	Kidney or Bladder Disorders	☐	☐	Arthritis, Rheumatism
☐	☐	Stroke	☐	☐	Shortness of Breath	☐	☐	Disease of the Thyroid	☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever	☐	☐	Asthma, Hay Fever	☐	☐	Cancer/ Chemotherapy	☐	☐	Venereal Disease
☐	☐	Heart Murmur	☐	☐	Diabetes (Sugar Disease)	☐	☐	Bleeding Disorders	☐	☐	Fainting Spells, Seizures
☐	☐	Mitral Valve Prolapse	☐	☐	Jaundice, Hepatitis	☐	☐	Herpes	☐	☐	Psychiatric Treatment
☐	☐	High Blood Pressure	☐	☐	Ulcers of the Stomach	☐	☐	Tuberculosis	☐	☐	A.I.D.S
☐	☐	Low Blood Pressure	☐	☐	Prosthetic Joints (knee/hip/shoulder)	☐	☐	Eye Disorders, Glaucoma	☐	☐	STD

As far as you know, are you allergic to any medicines?	YES	NO
Penicillin, codeine, sulfa, Tetracycline, Dental Anesthetics, Latex, Milk? …….	☐	☐
Are you taking any anti-depressants/mood stabilizers? ……..…….…….	☐	☐
Are you taking any ADHD Medications?……...…….…….	☐	☐
Have you ever had excessive bleeding following extraction of teeth or from a cut? ……	☐	☐
Have you ever had severe pains of the face or head? ……	☐	☐

I AUTHORIZE THE RELEASE OF ALL DENTAL INFORMATION ABOUT ME OR MY MINOR CHILDREN TO PHYSICIANS, HOSPITALS, INSURANCE COMPANIES AND DENTISTS AND I AUTHORIZE DR GOLAB TO PROVIDE THE NECESSARY DENTAL TREATMENT.

Signature _____ **Date** _____

MEDICAL UPDATE:

DATE	DETAILS

DATE	DETAILS