Mindy Paticoff-Weinman, DDS David Weinman, DDS

Welcome to our office! In order to provide you with better care, we require the following information and medical history. <u>All information is considered confidential.</u>

Name _____ Today's date _____

Address _____ City _____ Zip _____

Home phone _____ Cell Phone _____

Work phone _____

May we contact you at work? (*circle one*)...Yes No If no, in an emergency?…… Yes No

Date of Birth _____Occupation _____

Social Security No._____ Spouse's name _____

E-mail address (if applicable) _____

Would you like to receive recall notices by email? Yes No

<u>If you have dental insurance:</u>

Dental Insurance carrier _____ Name of Insured _____

Insured's employer _____ Insured's Social Security No. _____

Your relationship to insured (self, spouse, child) _____Insured's date of birth _____

If over 18 (*and claiming student status on insurance*) – what school do you attend ?

_____

<u>If you are a new patient to our office:</u>

Whom may we thank for referring you to our office? _____

When was your last dental appointment? _____

Have you ever been referred to a periodontist? _____

Have you had any trouble associated with previous dental treatment?
If so, please explain _____

_____

Please go to second page.

Medical History

Although dental personnel primarily treat the area in and around your mouth, y our mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationahip with the dentistry you will receive. Thank you for answering the following questions

Are you under a physician's care now? O Yes O No Physician's name:_____
Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain:_____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:_____
Do you use tobacco? O Yes O No
Do you use controlled substances? O Yes O No
Are you taking any medications, pills, or drugs? O Yes O No If yes, Please list:_____
_____

Women: Are you:
Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following:
___Aspirin ___Penicillin __Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetics

___Other If yes, please explain:_____

Do you have, or have you had, any of the following? (please check any that apply)

____AIDS/HIV Positive	____Congenital Heart Disorder	____Herpes
____Alzheimer's Disease	____Convulsions	____High Blood Pressure
____Anaphylaxis	____Cortisone Medicine	____Hypoglycemia
____Anemia	____Diabetes	____Irregular Heartbeat
____Angina	____Drug Addiction	____Low Blood Pressure
____Arthritis/Gout	____Emphysema	____Pain in Jaw Joints
____Artificial Heart Valve	____Epilepsy or Seizures	____Psychiatric Care
____Artificial Joint	____Excessive Bleeding	____Radiation Treatments
____Asthma	____Frequent Headaches	____Shingles
____Blood Disease	____Glaucoma	____Sinus Trouble
____Blood Transfusion	____Hay Fever	____Stroke
____Breathing Problem	____Heart Attack/Failure	____Swelling of Limbs
____Bruise Easily	____Heart Pace Maker	____Thyroid Disease
____Cancer	____Hearth Trouble/Disease	____Tonsillitis
____Chemotherapy	____Hemophilia	____Tuberculosis
____Chest Pains	____Hepatitis A	____Tumors or Growths
____Cold Sores/Fever Blisters	____Hepatits B or C	____Ulcers

Have you ever had surgery or radiation for a tumor, cancer diagnosis or condition of the head and neck? (If yes, please explain)

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____Date_____