PATIENT INFORMATION

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental care needs, please fill out these forms completely.

Date_____

Patient Name_____

First Middle Last

I prefer to be called_____

Date of Birth_____ SSN_____

Sex: _____Male _____Female Marital Status: ___M ___S ___D ___Sep. ___Wid. ___Minor

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Employer_____ Work Phone_____

Spouse's Name_____

Date of Birth_____ SSN_____

Spouse's Employer_____

Whom may we thank for referring you:_____

Person to contact in case of emergency

Name_____ Relationship_____ Phone_____

PATIENT INSURANCE INFORMATION

Primary Dental Insurance Information

Insured's Name_____

Relationship to Patient_____

Insured's DOB_____

Insurance Co._____

Address_____

City_____State_____Zip_____

Phone_____

Insured's ID or SSN_____

Group or Plan #_____

Secondary Dental Insurance Information

Insured's Name_____

Relationship to Patient_____

Insured's DOB_____

Insurance Co._____

Address_____

City_____State_____Zip_____

Phone_____

Insured's ID or SSN_____

Group of Plan #_____

Please keep in mind that your insurance benefits are based on a contract between your employer and the insurance company. Most insurance companies provide coverage for only a limited number of services depending on which policy your employer has purchased and reimbursement may vary for out-of-network providers.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all dental, medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance and any other health plans, to Michael A. Gordon, D.D.S., P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ _____

Signature of Patient, Parent or Guardian (if patient is a minor) Date

Patient Name: _____ Date:_____

MEDICAL HISTORY

THIS INFORMATION IS VERY IMPORTANT, ACCURATE ANSWERS ARE ESSENTIAL.
Answer all questions by circling Yes (Y) or No (N) and circle or list all that pertain.All responses are kept confidential.

1. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

A. Aspirin or Ibuprofen?..... Y / N
B. Codeine or other pain killers?..... Y / N
C. Eggs?..... Y / N
D. Latex or rubber products?..... Y / N
E. Local Anesthesia (Novocaine, etc.)?..... Y / N
F. Penicillin or other antibiotics?..... Y / N
G. Sedatives, Barbiturates?..... Y / N
H. Other allergies or reactions?..... Y / N
If so, please list: _____

2. ARE YOU USING ANY OF THE FOLLOWING:

A. Antibiotics? ..... Y / N
B. Anticoagulants (Blood Thinners)?..... Y / N
C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?..... Y / N
D. High Blood Pressure medications?..... Y / N
E. Steriods (Cortisone, etc.)?..... Y / N
F. Tranquilizers?..... Y / N
G. Insulin or Oral Anti-Diabetic drugs?..... Y / N
H. Digitalis, Inderal, Nitroglycerin or other heart drug?..... Y / N
I. Have you ever taken medication for osteoporosis?..... Y / N
J. Have you ever been on a bisphosphonate such as:
Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel),
Ibandronate (Boniva), Pamidonate (Aredia), Risedronate (Actonel,
Actonel w/Calcium), Tiludronate (Skelid), Zoledronic acid (Reclast, Zometa)?..... Y /N
K. Have you been treated for metastatic or bone cancer?..... Y /N
L. MEDICATIONS: Please list all of your current medications include all over-the-counter prescription medications, herbal or holistic remedies, vitamins and minerals:

_____
_____
_____
_____

3. DO YOU HAVE OR HAVE YOU EVER HAD:

A. Any significant injuries, disease or genetic condition resulting in a significant disability or altered activities?..... Y / N
B. Rheumatic Fever or Rheumatic Heart Disease?..... Y / N
C. Congenital Heart Disease?..... Y / N
D. Cardiovascular Disease (Angina, Congestive Heart Failure, Coronary Artery Disease, Heart Attack, Heart Murmur, Heart Surgery, Heart Trouble, High Blood Pressure, Mitral Valve Prolapse, Pacemaker, Palpitations, Stroke)?..... Y / N
E. Swelling of Ankles?..... Y / N
F. Artificial valves or joints placed anywhere in your body(Heart Valve, Hip,Knee)?..... Y / N
G. Lung Disease (Asthma, Bronchitis, Chest Pain, Chronic Cough, Emphysema, Pneumonia, Severe Cough, Shortness of Breath, Tuberculosis)?..... Y / N

Patient Name:_____ Date_____

3 Cont. DO YOU HAVE OR HAVE EVER HAD:

H. Convulsions, Dizziness, Epilepsy, Fainting, Seizures?..... Y / N
I. Anemia, Bleeding Disorder, Bleeding Tendency, Blood Transfusion…… Y / N
or do you bruise easily?..... Y / N
K. Kidney Disease?..... Y / N
L. Diabetes?..... Y / N
M. Hypothyroidism, Hyperthyroidism, or Thyroid Disease (Goiter)?..... Y / N
N. Arthritis or Rheumatism?..... Y / N
O. Colitis, GERD, Stomach Ulcers?..... Y / N
P. Glaucoma?..... Y / N
Q. Cancer?...Y / N Type:_____
R. Radiation (X-Ray) treatment for Cancer?..... Y / N
S. Nasal or Sinus Problems?..... Y / N
T. Any disease, drug or transplant that has depressed your immune system?..... Y / N
U. AIDS or HIV?..... Y / N
V. Sexually Transmitted Disease?..... Y / N
W. Sickle Cell Anemia?..... Y / N
X. Cold Sores or Herpetic Lesions?..... Y / N

4. Are you in good health?..... Y / N
5. Has there been any changes in your general health in the past year?..... Y / N
6. Physician's Name:_____Phone:_____
7. Date of last physical exam?_____
8. Are you now under a physician's care for a particular problem?..... Y / N
If so, please list:_____
9. Have you ever had any serious illnesses, surgeries or hospitalizations?..... Y / N
If so, list: _____
10. Do you smoke or chew tobacco?...Y / N If yes, how much per day? _____
11. Do you wear contact lenses? If so, what kind?_____ Y / N
12. Is there any history of Alcohol or Chemical Dependency?..... Y / N
13. Is there any history of Emotional Disorder or Psychiatric Care?..... Y / N
14. Do have any other disease, condition, or problem not listed above? …… Y / N
15. Do you wish to talk to the doctor privately about anything?..... Y / N
16. FOR WOMEN ONLY:
A. Are your pregnant, or is there any chance you might be pregnant?..... Y / N
B. Are you nursing?..... Y / N
C. Are you using oral contraceptives?..... Y / N

If you are using oral contraceptives, it is important that you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

DENTAL HISTORY

Reason for today's visit?_____

Previous Dentist? _____

Date of last dental visit? _____ Date of last dental x-rays?_____

1. Have you had any serious problems associated with any previous dental treatment?
If so, explain: _____

2. Do you have or have had any of the following:

Bad Breath…Y / N	Bleeding Gums…Y / N	Blisters on lips or mouth…Y / N
Burning sensation on tongue…Y / N	Chew on one side of mouth…Y / N	Clicking or popping…Y / N
Dry Mouth…Y / N	Fingernail biting…Y / N	Food collection between teeth…Y / N
Foreign Objects…Y / N	Grinding Teeth…Y / N	Gums swollen or tender…Y / N
Jaw pain or tiredness…Y / N	Lip or cheek biting…Y / N	Loose teeth or broken fillings…Y /N
Mouth breathing…Y / N	Mouth pain…Y / N	Orthodontic treatment…Y / N
Pain around ear…Y / N	Periodontal Treatment…Y / N	Sensitivity to cold…Y / N
Sensitivity to heat…Y / N	Sensitivity to sweets…Y / N	Sensitivity when biting…Y / N
How often do you brush?_____		How often do you floss?_____

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I certify that I have read and understand the questions on pages 2-4. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____

Signature of Person Completing Health History | Date | Dr.'s Initials

Date Reviewed_____ Initials_____

Date Reviewed_____ Initials_____

Date Reviewed_____ Initials_____

Date Reviewed_____ Initials_____