

CONFIDENTIAL PATIENT INFORMATION

Date: _____

PATIENT INFORMATION

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ e-mail: _____

Driver's License/State ID#: _____

Birth date: _____ Sex: _____ Marital Status: _____ Occupation: _____

Spouse Name: _____ Referred by: _____

PERSON RESPONSIBLE FOR ACCOUNT **Same as above**

Name: _____ SS#: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

Driver's License/State ID#: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ SS# _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ SS# _____

Employer: _____ Policy #: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement

SIGNATURE: _____	DATE: _____
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ISLAND SMILES
Guy Chisteckoff, DDS

CONFIDENTIAL PATIENT INFORMATION

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____ City: _____ State: _____

Date of last dental visit: _____ Date of last dental xrays: _____

Check box if you have had any of the following:

Bad breath	Foreign objects	Periodontal treatment
Bleeding gums	Grinding teeth	Sensitivity to cold
Blisters on lips or mouth	Gums swollen or tender	Sensitivity to heat
Burning sensation on tongue	Jaw pain or tiredness	Sensitivity to sweets
Chew on one side of mouth	Lip or cheek biting	Sensitivity when biting
Cigarette, pipe, or cigar smoking	Loose teeth or broken fillings	Sores or growths in your mouth
Clicking or popping jaw	Mouth breathing	How often do you floss?
Dry mouth	Mouth pain, brushing	
Fingernail biting	Orthodontic treatment	How often do you brush?
Food collection between the teeth	Pain around ear	

HEALTH INFORMATION

Personal Physician Name: _____

Personal Physician Address: _____

YES	NO	PLEASE ANSWER THE FOLLOWING QUESTIONS
		Have you been hospitalized within the past 2 years? For What?
		Are you currently being treated by a physician? For what?
		Are you currently taking any medications or drugs? What?
		Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
		Are you allergic to any drugs? What?
		Are you allergic to any metals? What?
		Have you ever had a skin rash or other reaction to metal jewelry? What?
		Do you bleed excessively upon injury?

YES	NO	PLEASE ANSWER THE FOLLOWING QUESTIONS
		Are you pregnant?
		Have you ever been involved with dental/medical legal activity? When?

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD

AIDS	Epilepsy	High Blood Pressure	Rheumatic Fever
Arthritis	Glaucoma	Jaundice	Asthma
Heart Murmur	Kidney Problems	Stroke	Tuberculosis
Cancer	Heart Problem*	Low Blood Pressure	Other Diseases*
Diabetes	Hepatitis	Nervous Breakdown	STD
	Pace Maker	Or Psychiatric Therapy	sexually transmitted disease

If you circled either "Heart Problems" or "Other Diseases", please describe condition:

PERSON TO BE CONTACTED IN CASE OF EMERGENCY (OTHER THAN RELATIVE)

Name: _____

Address: _____

Telephone: (Home) _____ (Work) _____

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:	DATE:
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Patient Name: _____

Initial Date: _____

Update: _____

Update: _____

Update: _____

Update: _____