Dental Health

When was your last dental visit? Yes ❑ No ❑

Have you ever had any problems associated with previous dental treatment? Yes ❑ No ❑

If yes, explain: _____

How often do you brush your teeth? _____

How often do you floss? _____

Do you routinely use a mouth rinse? Yes ❑ No ❑ How often? _____

Please describe any dental issues you may be experiencing: _____

_____

_____

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices:

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

Credit Card on File:

We will bill your insurance carrier for services provided and will accept assignment of benefits. However, we will bill your credit card for any unpaid balances.

Name of cardholder _____

Credit card number _____

Expiration date _____ Billing Zip code _____

Signature _____

Consent:

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patients' dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

_____
Patient Signature (parent if child) Date

_____
Dentist Signature Date

BK Barry Kaplan DMD

Patient Health Record

Date _____

Name (Last) _____ (First) _____ (Middle) _____

Home address _____

City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____

Work Phone Number _____ Ext. _____

Email: _____

Social Security Number _____

Occupation _____

Name of Business _____

City _____ State _____ Zip _____

Work Phone: _____

Date of Birth _____ Sex _____ Height _____ Weight _____

Marital Status (Please check one) Single ❑ Married ❑ Widowed ❑ Divorced ❑

Spouse's Name _____ D.O.B. _____

Spouse's Employer _____

Referred By _____

Emergency Contact Information

Name, address and telephone number of an individual we can call

_____

_____

Medical Health

General Health (Please check one) Excellent ❑ Good ❑ Fair ❑ Poor ❑

Name and address of physician _____

Last complete physical? _____

Pharmacy Name _____ Phone Number _____

Are you presently under the care of a physician? Yes ❑ No ❑

If so, for what reason? _____

Are you taking medications now? Yes ❑ No ❑

Please list _____

_____

Are you taking any herbal medications? Yes ❑ No ❑

Please List _____

_____

Are you taking Aspirin daily? Yes ❑ No ❑

Are you allergic to: Antibiotics ❑ Codeine ❑ Aspirin ❑ Local Anesthetics ❑

Are you allergic to any other medications? _____

_____

Have you ever been hospitalized? Yes ❑ No ❑

If so, give name of hospital, reason and dates _____

_____

Have you had any radiological x-rays the last five years? Yes ❑ No ❑

Have you had any blood transfusions? Yes ❑ No ❑

Are you currently trying to modify your weight? Yes ❑ No ❑

Have you experienced any sudden weight changes? Yes ❑ No ❑

Do you take any weight reduction medications? Yes ❑ No ❑

Do you smoke cigarettes? Yes ❑ No ❑

How many per day? _____

Do you consume alcohol on a daily basis? Yes ❑ No ❑

Women:

Are you pregnant? Yes ❑ No ❑

How far along? _____

Do you experience pre-menstrual syndrome? Yes ❑ No ❑

Are you taking birth control pills? Yes ❑ No ❑

Do you have or have you ever had any of the following:

Chest Pains	❑	Fainting Spells	❑
Heart Disease	❑	Hypertension	❑
Rheumatic Fever	❑	Congenital Heart Defects	❑
Kidney Problems	❑	Heart Murmur	❑
Stroke	❑	Thyroid Problems	❑
Hormonal Problems	❑	Ulcers	❑
Tuberculosis	❑	Diabetes	❑
Epilepsy/Seizures	❑	Anemic	❑
Cancer/Leukemia	❑	Psychiatric Problems	❑
Sickle Cell Disease	❑	Glaucoma	❑
Prosthetic Heart Valve	❑	Bruise Easily	❑
Jaundice	❑	Asthma/Hay Fever	❑
AIDS/HIV	❑	Sinus Trouble	❑
Allergies/Hives	❑	Excessive Thirst Urination	❑
Arthritis	❑	Prolonged Bleeding	❑
Persistent Cough	❑	Genetic Problems	❑
Sexually Transmitted Disease	❑	IDS	❑
Skin Disease	❑	Prolonged Sore Throat	❑
Unexplained Fevers	❑	Night Sweats	❑
Enlarged Lymph Nodes	❑	Blue/Red Lesions	❑
Persistent Diarrhea	❑	Prosthetic Joints	❑
Fatigue	❑		

Have you ever been tested for Hepatitis? Yes ❑ No ❑

Have you ever been diagnosed with or told you were a carrier of Hepatitis A,B,C or NONA/NONB? Yes ❑ No ❑

Do you have a history of cold sores, fever blisters or canker sores? Yes ❑ No ❑

Are you being treated with immunosuppressive drugs? Yes ❑ No ❑

Have you ever used drugs for recreational purposes? Yes ❑ No ❑