Bhargava
FAMILY DENTISTRY

Patient Information

Patient Name ______________________ Today's Date ______________
Home Address ______________________ Date of Birth ______________
City / State ______________ Zip Code ________ Home Phone ______________
Email Address (optional)______________________ Cell Phone ______________
❑ Check here if you prefer to receive appointment confirmations by email. Work Phone ______________

Patient Social Security #________ - ________ - _________ (We will only use this for insurance purposes, not as as ID#)
Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient Employer Name (or Parent/Guardian) ______________________
Patient Employer Address (or Parent/Guardian) ______________ City / State ______________ Zip Code__________
Spouse (if applicable) Name & Employer ______________________ Work Phone ______________

In case of emergency, we will contact your spouse first. Please list another emergency contact and phone number.
Emergency Contact Name ______________________ Phone Number ______________
If you are a college student, Name of School / College ______________________

Who may we thank for referring you? Name______________________ ❑ Check here if he/she is a current patient.
❑ Insurance Company ❑ Phone Book ❑ Insurance Web Site ❑ Newspaper ❑ Other______________________

I certify that I have read and understand the information on the reverse page. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information about my health/medical history can be dangerous to my health.

Signature: ______________________ *Date:* ______________

Responsible Party / Insurance Information

Dental Insurance
Primary Carrier of Insurance (if different from above)______________________
Primary Carrier: Social Security #________ - ________ - _________ Date of Birth ______________

Relationship to Patient______________________ Home Phone ____________ Work Phone ____________
Address______________________ City / State / Zip______________________

Insurance Company______________________ Group # and/or ID # ______________________
Insurance Co. Address ______________________ City / State / Zip______________ Phone ____________

Do you have any secondary/additional dental insurance? ❑ Yes ❑ No If yes, please provide the necessary information (insurance card/documentation).
Secondary Insurance Company ______________________ Group # and/or ID # ______________________

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE. CHECKS, DISCOVER, VISA, MASTERCARD ARE ACCEPTED.

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Patient Medical / Dental History

Physician ______________________ Office Phone ______________

Previous Dentist *(if applicable)* ______________________ Office Phone ______________

Circle or mark Y for YES, N for NO

Are you under medical treatment now (excluding routine checkups)? .... Y N

Has your MD ever instructed you to take antibiotics before visiting the dentist? .... Y N

Have you ever been hospitalized for any surgical operation or serious illness in the past 5 years?... Y N

Are you taking any bisphosphonate drugs such as Aredia, Fosamax, or Zometa? .... Y N

Have you ever taken FEN-PHEN / REDUX? .... Y N

Are you taking any MEDICATIONS? .... Y N

Please list ALL, including non-prescription (attach list if needed):

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Do you use tobacco? .... Y N
Frequency______________

Do you use alcohol? .... Y N
(other than occasionally)

Do you use cocaine or other drugs? .... Y N

Do you have a persistent cough or .... Y N
throat clearing associated with a known illness (lasting more than 3 weeks)?

Are you ALLERGIC or have any REACTIONS to the following?

Local Anesthetics (i.e. lidocaine, novacaine) .... Y N

Penicillin or other antibiotics .... Y N

Sulfa Drugs .... Y N

Barbiturates .... Y N

Sedatives .... Y N

Iodine .... Y N

Aspirin .... Y N

Latex .... Y N

Codeine .... Y N

Other______________

Women Only:

Are you pregnant or possibly pregnant? .... Y N

Are you nursing? .... Y N

Are you taking birth control pills? .... Y N

Please circle if you have had any of the following:

AIDS/HIV	**Frequently Tired**	**Mitral Valve Prolapse**
Anemia	**Glaucoma**	**Radiation Treatment**
Angina	**Hay Fever**	**Respiratory Problems**
Arthritis	**Heart Attack**	**Recent Weight Loss**
Asthma	**Heart Diseases**	**Rheumatic Fever**
Cancer	**Heart Murmur**	**Sexually Transmitted Diseases**
Cardiac Pacemaker	**Hepatitis**	**Stomach Trouble**
Chest Pains	**High Blood Pressure**	**Stroke**
Diabetes	**Joint Replacement or Implant**	**Swollen Ankles**
Easily Winded	**Kidney Diseases**	**Thyroid Problems**
Empysema	**Leukemia**	**Tuberculosis**

Do your gums bleed while brushing or flossing? .... Y N

Are your teeth sensitive? .... Y N

Do you feel pain to any of your teeth? .... Y N

Do you have any sores or lumps in or near your mouth? .... Y N

Have you ever had any head, neck or jaw injuries? .... Y N

Have you ever experienced clicking of jaw, jaw joint/ear pain? .... Y N

Have you ever experienced difficulty in opening or chewing? .... Y N

Do you clench or grind your teeth? .... Y N

Do you have frequent headaches? .... Y N

Have you ever had orthodontic work? .... Y N

Have you ever had difficult extractions? .... Y N

Doctor's Comments:

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THIS OFFICE FOLLOWS THE HIPAA PRIVACY ACT. PLEASE READ OVER OUR NOTICE OF PRIVACY PRACTICES.
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