Bhargava
FAMILY DENTISTRY

Patient Medical / Dental History

Physician ______________________ Previous Dentist *(if applicable)* ______________________

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):

____
____
____
____
____

Do you use tobacco? .... Y N
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 been diagnosed with or have any of the following:

AIDS/HIV
Anemia
Angina
Arthritis
Asthma
Autism
Cancer
Cardiac
Pacemaker
Chest Pains
Crohn's Disease
Diabetes
Easily Winded

Empysema
Frequently Tired
Glaucoma
Hay Fever
Heart Attack
Heart Diseases
Heart Murmur
Hepatitis
High Blood Pressure
Joint Replacement or Implant
Kidney Diseases
Leukemia

Lupus
Mitral Valve Prolapse
Radiation Treatment
Respiratory Problems
Recent Weight Loss
Rheumatic Fever
Sexually Transmitted Diseases
Sjogren's Syndrome
Stomach Trouble
Stroke
Swollen Ankles
Thyroid Problems
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
Other concerns we should be aware of:

____
____
____

THIS OFFICE FOLLOWS THE HIPAA PRIVACY ACT. PLEASE READ OVER OUR NOTICE OF PRIVACY PRACTICES. PAYMENT IS EXPECTED AT TIME OF SERVICE.

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Patient Information

Patient Name ______________________ Today's Date ______________

Home Address ______________________ Date of Birth ______________

City / State ______________ Zip Code __________ Home Phone ______________

Email Address ______________________ Cell Phone ______________

Check appropriate box: ❑ Minor ❑ Single ❑ Married Gender: ❑ Male ❑ Female Work Phone ______________

Patient Social Security #________ - ________ - ________

We will only use this for insurance purposes, not as as ID#. If patient is a minor and you do not have Social Security Number, leave blank.

Emergency Contact Name ______________________ Phone Number ______________

Relationship to the Patient ______________________

Who may we thank for referring you? Name ______________________ ❑ Check here if he/she is a current patient.

❑ Insurance Company ❑ Phone Book ❑ Online ❑ Newspaper ❑ Other ______________________

Responsible Party / Insurance Information / Employment Information

Who is primarily responsible for patient? ❑ Self ❑ Other ______________________

Policy Holder of Insurance ______________________

Policy Holder Social Security #________ - ________ - ________ Date of Birth of Policy Holder ______________

Relationship to Patient ______________________ Home Phone __________ Work Phone __________

Address ______________________ City / State / Zip ______________

Employer ______________________ OR ❑ Self Employed / Self Funded

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 # ______________

To the best of my knowledge, the questions on both sides of 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:* ______________

PAYMENT IS EXPECTED AT TIME OF SERVICE.