Bhargava
Family Dentistry

Patient Information

MARCH 2022

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.

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Patient Medical / Dental History

MARCH 2022

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 throat clearing associated with a known illness (lasting more than 3 weeks)? ..... **Y N**

_____
_____
_____
_____
_____

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:

_____
_____
_____