

Patients Name: _____

Today's Date: _____

Patient DOB: _____

How did you hear about us? _____

Home Address: _____

Insurance Company: _____

Subscribers Name: _____

Preferred Phone #: _____

Subscribers DOB: _____

Email: _____

Member ID/SSN: _____ Group #: _____

Employer: _____

Previous Dentist: _____ Phone: _____

Occupation: _____

Approx. Date of last Exam: _____

Emergency Contact: _____

Reason for your visit: Routine Clenching/grinding Pain

Relationship: _____ Cell: _____

Whitening Implants Cosmetic Other _____

Women: Pregnant? Y/N Trying to become pregnant? Y/N Nursing? Y/N Taking oral contraceptives? Y/N

Allergies: Aspirin: Y/N Penicillin: Y/N Codeine: Y/N Acrylic: Y/N Metal: Y/N Latex: Y/N Sulfa Drugs: Y/N Peanuts: Y/N

Are you under the care of a physician now? **Y or N** If so, why? _____

Please list all medications and vitamins: _____

Do you use controlled substances? **Y or N** If so, what? _____

Have you ever been hospitalized, or had a major operation? **Y or N** If yes, what/when? _____

Pharmacy _____

Do you have or have you had any of the following?

Aids/HIV Pos.	Y or N	Jaundice	Y or N	Kidney Problems	Y or N
Anaphylaxis	Y or N	Diabetes	Y or N	Leukemia	Y or N
Anemia	Y or N	Drug Addiction	Y or N	Liver Disease	Y or N
Angina	Y or N	Emphysema	Y or N	Low Blood Pressure	Y or N
Arthritis	Y or N	Epilepsy	Y or N	Lung Disease	Y or N
Artificial Heart Valve	Y or N	Frequent Cough	Y or N	Mitral Valve Prolapse	Y or N
Artificial Joint	Y or N	Genital Herpes	Y or N	Osteoporosis	Y or N
Asthma	Y or N	Glaucoma	Y or N	Parathyroid	Y or N
Blood Disease	Y or N	Hay Fever	Y or N	Mental Disorder	Y or N
Blood Transfusion	Y or N	Heart Attack	Y or N	Radiation Treatment	Y or N
Breathing Problems	Y or N	Heart Murmur	Y or N	Dialysis	Y or N
Cancer	Y or N	Pacemaker	Y or N	Sinus Trouble	Y or N
Chemotherapy	Y or N	Hepatitis	Y or N	Spina Bifida	Y or N
Chest Pains	Y or N	High Blood Pressure	Y or N	Stomach disease	Y or N
Cold Sores	Y or N	High Cholesterol	Y or N	Stroke	Y or N
Heart Disorders	Y or N	Hypoglycemia	Y or N	Tuberculosis	Y or N

Is there any other health information not listed that Dr. Rustam Shukurov should be made aware of before treating you?

If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that by providing incorrect information, it can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any medical changes.

Patient Signature: _____ Date: _____

Update Date & Initial _____ Update Date & Initial _____ Update Date & Initial _____