Aaron Elkowitz, DMD, P.C.

Date: _____

Patient Information

Name: Dr. Mr. Mrs. Miss _____
Circle One First Name Middle Initial Last Name

Address:_____
Number & Street City State Zip Code

Phone:_____
Home# Work# Fax#

_____
Cellular Phone E-mail Address

_____
Date of Birth Social Security No. Driver's License No. & State

_____
Occupation Sex Marital Status Name of Spouse

_____
Closest Relative(Other than spouse) Phone Number Relationship

_____
Responsible Party of Account Address (If different from above) Relationship

_____
Insurance Carrier Group Number Relationship to Insured

_____
Employer Employer Address

_____
Referred By

DENTAL HISTORY

		Circle One	
1.	Are you having any specific problems with your teeth, gums, or mouth?	Yes	No
2.	Are your teeth sensitive to hot, cold, or sweets?	Yes	No
3.	Do your gums bleed after brushing; are they often sore or tender?	Yes	No
4.	Do you have any difficulty chewing your food?	Yes	No
5.	Do you have any or frequently get fever blisters, mouth ulcers, or sores on your lips or mouth?	Yes	No
6.	Do you often have chapped lips, cracked or raw places on corners of your mouth?	Yes	No
7.	Do you frequently get food wedged between your teeth?	Yes	No
8.	Have you ever worn braces or a retainer for straightening your teeth?	Yes	No
9.	Do you smoke or chew tobacco in any form?	Yes	No
10.	Are you unhappy with the appearance of your teeth?	Yes	No
11.	Do you clench or grind your teeth?	Yes	No
12.	Do you notice clicking , popping, or soreness of the jaws or points just in front of the ears? Which Side? Left or Right (Circle)	Yes	No
13.	Do you ever have frequent headaches, earaches, stiffness, or soreness in your neck?	Yes	No
14.	When was your last dental check-up?_____		
15.	When were your teeth cleaned last? _____		
16.	When were your last set of dental x-rays? _____		

MEDICAL HISTORY

Circle One

1. Are you in good health? Yes No

2. Has there been any change in your general health within the past year? Yes No

3. Are you now under the care of a physician? Yes No
   If so, what is the condition being treated?
4. The name and address of my physician is: _____
   _____
   _____
5. When was your last physical examination?

6. Have you had any serious illness or operation? Yes No
   If so, what was the illness or operation?

7. Have you been hospitalized or had a serious illness within the past 5 years? Yes No
   If so, what was the problem?_____

8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial heart valves, or **Mitral Valve Prolapse**? Yes No
   b. Congenital heart lesions? Yes No
   c. Cardiovascular disease(heart trouble, heart attack, coronary disease, high blood pressure, arteriosclerosis, stroke) Yes No
      1) Do you have chest pain upon exertion? Yes No
      2) Are you ever short of breath after mild exercise? Yes No
      3) Do your ankles swell? Yes No
      4) Do you get short of breath when you lie down, or do you require an extra pillow when you sleep Yes No
      5) Do you have a cardiac pacemaker? Yes No
   d. ALLERGIES: i.e. LATEX, NICKEL, SILVER Yes No
   e. Sinus trouble? Yes No
   f. Asthma or hay fever? Yes No
   g. Hives or a skin rash? Yes No
   h. Fainting spells or seizures? Yes No
   i. Diabetes? Yes No
      1) Do you have to urinate (pass water) more than six times a day? Yes No
      2) Are you thirsty much of the time? Yes No
      3) Does your mouth frequently become dry? Yes No
   j. Hepatitis, jaundice, or liver disease? Yes No
   k. Arthritis or Inflammatory rheumatism (painful swollen joints)? Yes No
   l. Do you have any artificial joints(i.e. hips, knees, elbows) Yes No
   m. Stomach ulcers? Yes No
   n. Kidney trouble or disease? Yes No
   o. Tuberculosis (T.B.)? Yes No
   p. Do you have a persistent cough or cough up blood? Yes No
   q. Low blood pressure? Yes No
   r. Venereal disease? Yes No
   s. AIDS or HIV infection? Yes No
   t. Other?

9. Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No
   a. Do you bruise easily? Yes No
   b. Have you ever required a blood transfusion? Yes No
      If so, explain the circumstances?

10. Do you have any blood disorder such as anemia? Yes No

11. Are you allergic or have you reacted adversely to:
   a. Local anesthetics? Yes No
   b. Penicillin or any other antibiotic? Yes No
   c. Sulfa Drugs? Yes No
   d. Barbituates, sedatives, or sleeping pills? Yes No
   e. Aspirin, ibuprofen, or acetaminophen? Yes No
   f. Iodine? Yes No
   g. Codine or any other narcotic? Yes No
   h. Other:

Circle One

12. Are you taking any of the following types of medications:

a. Antibiotics or sulfa drugs? Yes No
b. Anticoagulants (blood thinners)? Yes No
c. Medicine for high blood pressure? Yes No
d. Cortisone (steroids)? Yes No
e. Tranquilizers? Yes No
f. Antihistamines? Yes No
g. Aspirin? Yes No
h. Insulin, tolbutamide (Orinase) or similar drug? Yes No
i. Digitalis or drugs for heart trouble? Yes No
j. Nitroglycerin? Yes No
k. Oral contraceptive or other hormonal therapy? Yes No

13. Please list all medications and the dose you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

14. Do you use any tobacco products? Yes No
If so, how much per day and what?

15. Do you use any alcoholic products? Yes No
If so, how much per day/week/month and what?

16. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? Yes No

17. Are you wearing contact lenses? Yes No

18. Do you have any disease, condition, or problem not listed above? Yes No
If so, please explain: _____
_____

WOMEN

19. Are you pregnant? Yes No

20. Do you have any problems associated with your menstrual period? Yes No

21. Are you nursing? Yes No

22. Are you taking oral contraceptives? Yes No

I certify that I have read the above questions and answered them to the best of my ability. I acknowledge that my questions about the inquiries set forth above have been answered to my satisfaction. I will not hold Aaron Elkowitz, DMD,P.C., or any other member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

I understand that I am responsible for my account, regardless of any insurance plan I may have. Payment for services is due at the time services are rendered with the exception when payment arrangements have been approved in advance by our staff. We accept cash, checks, Mastercard, and Visa. Finance charges of 1 1/2%per month will be applied to accounts over 60 days and in the event of default to pay reasonable collection charges and/or attorney fees.

_____

Signature of Patient or Responsible Party Date

For completion by the Dentist.

Comments on patient interview concerning medical history.

Comment on significant dental findings.

Circle All That Apply

Need for medical consultation with patients doctor(s)

Need for premedication letter

_____

Signature of Dentist Date

MEDICAL HISTORY UPDATE

Date	Comments	Patient's Signature