

Name _____ D.O.B. _____ Marital Status _____

Address _____ Res. Phone _____ Cell Phone _____

Occupation _____

Soc. Sec. No. _____ Employer _____ Phone _____

Insurance Coverage Yes ___ No ___ If yes, type _____

Physician _____ Date of last physical _____ Referred by _____

Email address _____

Dental History

Please Circle

- Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? _____ Yes No
Would you like whiter teeth? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

- Are you under a physician's care now? Why? _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below
[] Aspirin [] Penicillin [] Codeine [] Acrylic [] Metal [] Latex Rubber [] Other _____ Yes No
WOMEN (Please check): [] Pregnant/trying to get pregnant [] Nursing [] Taking oral contraceptives Discuss _____ Yes No
Have you ever taken Bisphosphonates (eg. Zometa, Aredia, Fosamax, etc. _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

Table with 5 columns of medical conditions and Yes/No checkboxes. Conditions include Heart Trouble/Disease, Bruise Easily, Emphysema, Yellow Jaundice, Cold Sores, etc.

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings: _____

I grant Dr. Alan M. Kasperowski or Dr. Bryan M. Kasperowski permission to administer necessary anesthetics and medications and to employ procedures necessary for the diagnosis and treatment of my oral cavity.

Patient

Parent or Guardian