WELCOME

Dr. David Moran, DMD
Dr. Koral Modi, DMD
Dr. Kimberly Minassian, DMD
Dr. Kerry Gallagher, DMD
Dr. Shruti Patel, DMD
Dr. Sophie Jo, DDS

PATIENT INFORMATION

PATIENT NAME: ____ DATE: _________________

BIRTHDATE: ___________________ SEX: M/F AGE:__________ SS#:____________________________

CELL PHONE: _______________________ EMAIL:____________________________

PATIENT EMPLOYER: __________________________ EMPLOYER PHONE: _________________________

OCCUPATION: __________________________ MARTIAL STATUS: MARRIED ____ SINGLE____ WIDOWED _____ DIVORCED_____ PARTNERS_____ SPOUSE'S NAME: ___________________

SPOUSE EMPLOYER: ______________ WHOM MAY WE THANK FOR REFERRING YOU?
____

DENTAL INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT:__________________________________
RELATIONSHIP TO PATIENT:
____
INSURANCE COMPANY: ____________________________
ID #: ___________________________ GROUP #: _________
POLICY HOLDER:_____________________________
BIRTHDATE: ___________ SS#: ____________________
RELATIONSHIP TO PATIENT: ________________________

DO YOU HAVE AN ADDITIONAL INSURANCE?
YES ____ NO___
POLICY HOLDER: ____________ INSURANCE COMPANY:__________ GROUP #: _________
ID #: _______________________
EMPLOYER:____________________________

ASSIGNMENT AND RELEASE:
I CERTIFY THAT I, AND/OR MY DEPENDENT(S) HAVE INSURANCE COVERAGE WITH ___________________________ AND ASSIGN DIRECTLY TO DR. __________________ (INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE I AUTHORIZE THE USE OF ALL MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVE NAMED DENTIOST MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

____
SIGNATURE OF PATIENT OR GUARDIAN

____
PRINTED NAME OF PATIENT OR GUARDIAN

IN CASE OF EMERGENCY

NAME: ____ RELATIONSHIP: ___________________________

PHONE: ___________________________________ ALTERNATIVE PHONE:____________________

DENTAL HISTORY

EARLIER FOR TODAYS VISIT: ____
FORMER DENTIST: ____ CITY: ____________________
STATE:_____
DATE OF LAST VISIT: _______________________ DATE OF LAST DENTAL X-RAYS: _______________________
PLACE A CHECK ON THE LINE IF YOU HAVE ANY OF THE FOLLOWING:

___ BAD BREATH
___ BLEEDING GUMS
___BLISTERS ON LIPS/MOUTH
___BURNING SENSATION ON TONGUE
___CHEW ON SIDE OF MOUTH
___CIGARETTE/PIPE/CIGAR SMOKING/VAPING
___CLICKING OR POPPING JAW
___DRY MOUTH
___FINGERNAIL BITING
___FOOD COLLECTION BETWEEN TEETH
___FOREIGN OBJECTS
___GRINDING TEETH
___GUMS SWOLLEN OR TENDER
___JAW PAIN OR TIREDNESS
___LIP OR CHEEK BITING
___LOOSE TEETH OR BROKEN FILLINGS
___ MOUTH BREATHING
___ MOUTH PAIN WHEN BRUSHING
___ORTHODONTIC TREATMENT
___PAIN AROUND EAR
___PERIODONTAL TREATMENT
___SENSITIVITY TO COLD
___ SENSITIVITY TO HEAT
___SENSITIVITY TO SWEETS
___SENSITIVITY TO BITING
___SORES OR GROWTHS IN YOUR MOUTH

HOW OFTEN DO YOU FLOSS: ______________________________
HOW OFTEN DO YOU BRUSH: ______________________________

MEDICAL HISTORY

WHO IS YOUR PRIMARY CARE PHYSICIAN? IF YES, WHO: ____

ARE YOU SEEING A SPECIALIST? IF YES, WHO: ____

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? ____ YES ____ NO. IF YES,
EXPLAIN:____

HAVE YOU EVER TAKEN FOSAMAX., BONIVA., ACTONEL., OR ANY OTHER MEDICATIONS CONTAINING BISPHONATES?
____

ARE YOU ON A SPECIAL DIET? ___ YES ___NO

DO YOU USE TOBACCO ___ YES ___NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

ARE YOU PREGNANT OR TRYING TO GET PREGNANT?
___ YES ___NO

DO YOU USE CONTROLLED SUBSTANCES

___ASPRIN ___ PENICILIN ___ CODEINE ___ ACRYLIC ___METAL ___ LATEX ___SULFA DRUGS __LOCAL ANETHETICS
___OTHER:____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:

DO YOU HAVE OR HAVE YOU HAD, ANY OF THE FOLLOWING?

___AIDS/HIV POSITIVE
___ALZHEIMERS
___ANAPHYLAXIS
___ANEMIA
___ANGINA
___ARTHRITIS/GOUT
___ARTIFICIAL HEART VALVLE
___ ARTIFICIAL JOINT
___ASTHMA
___BLOOD DISEASE
___BLOOD TRANSFUSION
____BREATHING PROBLEMS
___CANCER
___CHEMO THERAPY
___CHEST PAINS
___COLD SORES/FEVER BLISTERS
___CONGENITAL HEART DISORDER
___CONVULSION
___CORTISONE MEDICINE
___DIABETES
___DRUG ADDICTION
___EASILY WINDED
___EMPHYSEMA
___EPILEPSY SIEZURES
___EXCESSIBVE BLEEDING

___EXCESSIVE THIRST
___DIZZINESS
___FREQUENT COUGH
___FREQUENT DIARRHEA
___GENITAL HERPES
___GLAUCOMA
___HAY FEVER
___HEART ATTACK/FAILURE
___HEART MURMUR
___HEART PACEMAKER
___HEART ___TROUBLE/DISEASE
___HEMOPHILIA
___HEPATITUS A
___HEPATITUS B/C
___HERPES
___HIGH BLOOD PRESSURE
___HIGH CHOLESTEROL
___HIVES OR RASH
___HYPOLYGEMIA
___IRREGULAR HEARTBEAT
___KIDNEY PROBLEMS
___LEUKEMIA
___LIVER DISEASE
___LOW BLOOD PRESSURE
___LUNG DISEASE
___MTRAL VALVE PROLAPSE

___MTRAL VALVE PROLAPSE
___OSETOPEROSIS
___PAIN IN JAW JOINTS
___PARATHYROID DISEASE
___PSYCHIATRIC CARE
___RADIATION TREATMENTS
___RECENT WEIGHT LOSS
___RENAL DIALYSIS
___RHEUMATIC FEVER
___RHEUMATISM
___SCARLET FEVER
___SHINGLES
___SICKLE CELL DISEASE
___SINUS TROUBLE
___SPINA BIFIDA
___STOMACH/INTESTINAL DISEASE
___STROKE
___SWELLING OF LIMBS
___THYROID DISEASE
___TONSILITIS
___TUBERCULOSIS
___TUMORS OR GROWTHS
___ULCERS
___VENEREAL DISEASE
___YELOW JAUNDICE

ANYTHING NOT LISTED:____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ONT HIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENTS') HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

____ _________________

Signature of Patient or Guardian Date