CENTRAL PARK ORAL SURGERY

Andrei Mark, D.D.S. & Associates

The Dental Implant Specialists

Patient Information

Patient Name: _____ Birthdate ___/___/_____ Age _____
LAST FIRST MIDDLE

I prefer to be called: _____ □ Male □ Female Social Security #: _____

Home Address: _____
STREET CITY STATE ZIP

□ Single □ Married □ Partnered □ Divorced/Separated □ Widowed Drivers License #: _____

Home Phone #: (____) _____ - _____ Cell/Other #: (____) _____ - _____ Work Phone #: (____) _____ - _____ Ext: _____

Employer: _____ Occupation: _____ How long there? _____

Employer Address: _____
STREET CITY STATE ZIP

Where & When are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist (circle one): _____

Person Responsible for Account: _____

Spouse Information

His/Her Name: _____ Birthdate ___/___/_____ SS #: _____

Employer: _____ Work Phone: (____) _____ - _____ Cell/Other #: (_____) ____ - _____

Relative or friend not living with you:

His/Her Name: _____ Relation: _____

Employer: _____ Work Phone: (____) _____ - _____ Cell/Other #: (____) _____ - _____

Primary Insurance

Dental Coverage? □ Yes □ No Insurance Co. Name: _____

Insurance Co. Address: _____
STREET CITY STATE ZIP

Insurance Co. Phone #: (____) ____ - _____ Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate ___/___/_____ Insured's ID #: _____ Insured's Employer: _____

Secondary Insurance

Dental Coverage? □ Yes □ No Insurance Co. Name: _____

Insurance Co. Address: _____
STREET CITY STATE ZIP

Insurance Co. Phone #: (____) _____ - _____ Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate ___/___/_____ Insured's ID #: _____ Insured's Employer: _____

Medical History

Do you have a personal physician? □ Yes □ No

Physician's name: _____ Phone #: (____) _____ - _____

Date of last visit: ___/___/_____ Your current Physical Health is: □ Good □ Fair □ Poor

Are you currently under the care of a physician? □ Yes □ No Explain: _____

Are you taking any prescription / over-the-counter drugs? □ Yes □ No Please list each one: _____

Do you smoke or use tobacco in any other form? □ Yes □ No

Have you had any metal rods, pins, or implants? □ Yes □ No

Have you ever taken Fosamax, or any other bisphosphonate? □ Yes □ No

Have you ever taken Phen-fen? □ Yes □ No

For Women only:

Are you using prescription birth control? □ Yes □ No

Are you pregnant? □ Yes □ No

If yes, week #: _____

Are you nursing? □ Yes □ No

Have you ever had any of the following diseases or medical problems?
(Check if yes):

- □ Abnormal Bleeding / Hemophilia
- □ AIDS
- □ Alcohol / Drug Abuse
- □ Anemia
- □ Arthritis
- □ Artificial Bones / Joints / Valves
- □ Asthma
- □ Blood Transfusion
- □ Cancer / Chemotherapy
- □ Colitis
- □ Congenital Heart Defect
- □ Diabetes
- □ Difficulty Breathing
- □ Emphysema
- □ Epilepsy
- □ Fainting Spells
- □ Frequent Headaches
- □ Glaucoma
- □ Hay Fever
- □ Heart Attack / Surgery
- □ Heart Murmur
- □ Hepatitis
- □ Herpes / Fever Blisters
- □ High Blood Pressure
- □ HIV
- □ Hospitalized for Any Reason
- □ Kidney Problems
- □ Liver Disease
- □ Low Blood Pressure
- □ Lupus
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Psychiatric Problems
- □ Radiation Treatment
- □ Rheumatic / Scarlet Fever
- □ Seizures
- □ Shingles
- □ Sickle Cell Disease / Traits
- □ Sinus Problems
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis (TB)
- □ Ulcers
- □ Venereal Disease

Please list any other serious medical condition(s) that you have ever had:

_____

_____

_____

Are you allergic to any of the following?
(Check if yes):

- □ Aspirin
- □ Codeine
- □ Dental Anesthetics
- □ Erythromycin
- □ Jewelry / Metals
- □ Latex
- □ Penicillin
- □ Tetracycline
- □ Other

Please list any other drugs / materials that you are allergic to:

_____

_____

_____

Dental History

Why have you come to the dentist today?: _____

_____

Are you currently in pain? □ Yes □ No
Do you require antibiotics before dental treatment? □ Yes □ No
Your current dental health is: □ Good □ Fair □ Poor
Have you ever had serious / difficult problem associated with any previous dental work? □ Yes □ No
Do you floss daily? □ Yes □ No
Do you brush daily? □ Yes □ No
Type of bristles on your toothbrush: □ Hard □ Medium □ Soft
Have you ever had gum treatment? □ Yes □ No
Do your gums ever bleed? □ Yes □ No
Do they ever itch? □ Yes □ No

Have you ever had periodontal disease? □ Yes □ No
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? □ Yes □ No
Are your teeth sensitive to heat/cold/other? □ Yes □ No
If other, please specify: _____
Do you have any loose teeth? □ Yes □ No
D you still have wisdom teeth? □ Yes □ No
Would you like fresher breath? □ Yes □ No
Would you like whiter teeth? □ Yes □ No
Are you happy with how your smile looks? □ Yes □ No
If no, what would you change? _____

_____

Acknowledgement

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Payment is due in full at the time of treatment unless prior arrangements have been approved.
If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature: _____ Date ___/___/_____

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein. Initial: _____ Date ___/___/_____
Doctor's Comments: _____

_____

Medical History Update

Any changes in your health status since your last visit? □ Yes □ No Explain: _____

_____
PATIENT SIGNATURE DENTIST SIGNATURE DATE

Any changes in your health status since your last visit? □ Yes □ No Explain: _____

_____
PATIENT SIGNATURE DENTIST SIGNATURE DATE