

Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information

(Confidential)

Name: _____ Birthdate: _____ SS#/SIN: _____
 Address: _____ Date: _____
 City: _____ State: _____ Zip: _____
 Email: _____ Home phone: _____
 Cell phone: _____
 Fax: _____
 Check appropriate box: Minor Single Married Divorced Widowed Separated
 If student, name of school/college: _____ City: _____ State: _____ Full-time Part-time
 Patient or parent/guardian's name: _____
 Employer: _____ Work phone: _____
 Whom may we thank for referring you? _____
 Person to contact in case of emergency: _____ Phone: _____

Name of person responsible for this account: _____
 Relationship to patient: _____ SS#/SIN: _____ Birthdate: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home phone: _____ Cell phone: _____
 Email: _____
 Employer: _____ Work phone: _____
 Is this person currently a patient in our office? Yes No
 For your convenience, we offer the following methods of payment. Please check the option you prefer:
 Cash Personal check Visa MasterCard

Insurance Information

Name of insured: _____ Relationship to patient: _____
 Birthdate: _____ SS#/SIN: _____
 Name of employer: _____ Work phone: _____
 Address of employer: _____
 City: _____ State: _____ Zip: _____
 Insurance Company: _____ Group #: _____ Policy ID: _____
 Ins. Co. Address: _____ City: _____ State: _____ Zip: _____
 Do you have any additional insurance? Yes No If yes, please complete the following:
 Name of insured: _____ Relationship to patient: _____
 Birthdate: _____ SS#/SIN: _____
 Name of employer: _____ Work phone: _____
 Address of employer: _____
 City: _____ State: _____ Zip: _____
 Insurance Company: _____ Group #: _____ Policy ID: _____
 Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

(continued on next page)

HARVEY P BOYARSKY DMD

(continued from previous page)

Patient Medical History

Physician: _____ Office phone: _____ Date of last exam: _____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last five (5) years? Yes No
If yes, please explain: _____
3. Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, what medication(s) are you taking? _____
4. Have you ever used Fosamax, any Biophosphonate, or any medication to increase bone density? Yes No
5. Have you ever taken Fen-Phen/Redux? Yes No
6. Do you use tobacco? Yes No
7. Do you use controlled substances? Yes No
8. Are you wearing contact lenses? Yes No
9. Do you have or have you had any of the following?

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Chest pains
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Cardiac pacemaker	<input type="checkbox"/> Easily winded
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Stroke
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Angina	<input type="checkbox"/> Hay fever/allergies
<input type="checkbox"/> Fainting/seizures	<input type="checkbox"/> Frequently tired	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Radiation therapy
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Epilepsy/convulsions	<input type="checkbox"/> Cancer	<input type="checkbox"/> Recent weight loss
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Joint replacement or implant	<input type="checkbox"/> Heart trouble
<input type="checkbox"/> Kidney diseases	<input type="checkbox"/> Hepatitis/jaundice	<input type="checkbox"/> Respiratory problems
<input type="checkbox"/> AIDS of HIV infection	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> Thyroid problem	<input type="checkbox"/> Stomach troubles/ulcers	<input type="checkbox"/> Other _____
10. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Penicillin or any other antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sulfa Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Barbiturates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sedatives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Iodine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex rubber	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other (please list) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes No
12. Women only
 - a) Are you pregnant or think you may be pregnant? . . . Yes No
 - b) Are you nursing? Yes No
 - c) Are you taking oral contraceptives? Yes No

Patient Dental History

Name of previous dentist and location: _____ Date of last visit: _____

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes No
4. Do you feel pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you ever experienced any of the following problems in your jaw?

<input type="checkbox"/> Clicking	<input type="checkbox"/> 8. Do you have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Pain (joint, ear, side of face)	<input type="checkbox"/> 9. Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Difficulty in opening or closing	<input type="checkbox"/> 10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Difficulty in chewing	<input type="checkbox"/> 11. Have you ever had difficult extractions in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever had any prolonged bleeding following extractions? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear dentures or partials? Yes No
If yes, date of placement: _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date: _____
Signature of patient (or parent/guardian if minor)