"Where Smiles Are Created!"

Date ____________

Name ______________________________ Soc. Sec. # ______________
Last Name First Name Initial

Address ______________________________

City ______________ State ______________ Zip ______________

E-mail ______________________________

Sex ❑ M ❑ F Birthdate ________ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by ______________________ Occupation ______________

Home Phone ______________ Business Phone ______________

Whom may we thank for referring you? ______________________________

In case of emergency who should be notified? ______________ Phone ______________

DENTAL HEALTH INFORMATION

	Yes	No
Are you having any discomfort?	❑	❑
Any sensitivity to hot, cold, sweets, chewing?	❑	❑
Does dental treatment make you nervous?	❑	❑
Have you experienced any of the following problems:		
Bleeding Gums	❑	❑
Bad breath	❑	❑
Soreness in jaw joint	❑	❑
Grinding of teeth	❑	❑
Loose teeth	❑	❑
Oral lesions/Cold sores/Canker sores	❑	❑
Dry mouth	❑	❑

On a scale of 1 to 10 with 10 being the highest rating:

(circle one)

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

	Yes	No
Do you think your dental health effects your overall health?	❑	❑
Do you think it is important to have your teeth cleaned?	❑	❑

When was the last time you had an oral cancer exam?
____

	Yes	No
Do you smoke or use tobacco in any form?	❑	❑
Do you use illegal drugs?	❑	❑
Do you use alcohol?	❑	❑
Is the brightness of your teeth important to you?	❑	❑
If I could change my smile I would make my teeth:		
Whiter	❑	❑
Straighter	❑	❑
Close space	❑	❑
Replace black mercury fillings with tooth colored restorations	❑	❑
Have missing teeth replaced	❑	❑
Repair chipped teeth	❑	❑
Less gum showing	❑	❑
Replace old crowns or caps that don't match	❑	❑
Do you prefer to save your teeth?	❑	❑
Do you sleep with 2 or more pillows?	❑	❑

Date of last cleaning? __________

How often do you floss? _______ brush? ___________

What is the most important thing to you about your dental visit today? ______________________________
____

PLEASE READ: *I have answered the above questions and health history to the best to my knowledge. At each dental visit, planned procedures will be clearly explained before treatment is begun. On this basis, I give Dr. Dolberg, my consent to perform any needed dental treatment. Also, I understand that payment is due at the time of service and that if I do have dental insurance, that my insurance policy is only a contract between me and my insurance carrier and that I am personally responsible for all fees incurred for dental treatment.*

Patient ______________________________ *Date* ______________

Parent or Responsible Party ______________________ *Relationship to Patient* ______________

Brian S. Dolberg D.D.S., P.C. • 4390 N. Miller Rd., • Scottsdale, AZ 85251

Medical Health History

Patient Name: ______________________________ Date of Birth: ____________________

Physician's Name ______________________________ Phone ____________________

Date of last medical check up ______________________________

Have you ever been hospitalized for any surgical operation or serious illness? Yes No

If yes, For what and when: ______________________________

Have you ever had to pre-medicate with antibiotics prior to a dental visit? Yes No

If yes, what antibiotic and dosage do you take & why? ______________________________

List all medications that you are currently taking, including over the counter medications.

____

____

Do you have any allergies to any medications or have you ever had any reaction to the following…

Local Anesthetics Sulfa Penicillin Codeine Latex Other ____________________

Please indicate with a circle if you have had any of the following:

Artificial Heart Valves
Artificial Joints
Heart Murmur
Mitral Valve Prolapse
Pacemaker
Congestive Heart Failure
High or Low Blood Pressure
Rheumatic Fever
Stroke
Diabetes, Type ____________
Kidney Disease
Hepatitis, What Type ______
Liver Disease
Chemical Dependency

Thyroid Problems
Cancer, What type _________
Chemotherapy
Radiation Treatment
Asthma
Emphysema
Fainting or Dizziness
Shortness of Breath
Sinus Trouble
Arthritis / Rheumatism
Glaucoma
Headaches
Venereal Disease
Epilepsy

Neck / Back Problems
Swollen Neck Glands
Cortisone Treatments
Tuberculosis
Anemia
Bleeding Disorder
Acid Reflux / Ulcers
Special Diet
Unexplained Weight Loss
Swollen Feet / Ankles
Psychiatric Care
Parkinson's Disease
Herpes / Cold Sores
HIV / AIDS

Have you ever taken Redux, Phen-Phen or Fosamax (Bisphosphonates)? Y N

Women: Are you currently taking birth control medication? Y N
Are you pregnant? Y N Due date ______________
Are you nursing? Y N

Any other medical conditions not listed on this form? ______________________________

____

This above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Signature: ______________________________ *Date* ____________________

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