

WELCOME

Thank you for selecting our office! To help us process your insurance correctly, please fill out this form completely and notify us of any changes. We are happy to help, if assistance is required.

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____ Mr. Mrs. Ms. Dr.
I prefer to be called: _____ E-mail Address: _____
 Male Female Marital Status: Single Married Divorced Separated Date of Birth: _____
Minor: Yes No Name of School: _____ Full-time Student: Yes No

RESPONSIBLE PARTY INFORMATION:

Last Name: _____ First Name: _____ Date of Birth: _____
Soc. Sec. #: _____ Relationship to Patient: _____
Home Address: _____ Apt. No.: _____
City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Work #: _____ Ext: _____
Name of Employer: _____ Occupation: _____
Insurance Company: _____ Phone #: _____

ADDITIONAL INSURANCE INFORMATION:

Last Name: _____ First Name: _____ Date of Birth: _____
Soc. Sec. #: _____ Relationship to Patient: _____
Home Address: _____ Apt. No.: _____
City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Work #: _____ Ext: _____
Name of Employer: _____ Occupation: _____
Insurance Company: _____ Phone #: _____

Nearest Relatives

Last Name: _____ First Name: _____ Phone#: _____
Last Name: _____ First Name: _____ Phone#: _____

Who May We Thank For Referring You?

Referred by a Friend (Name of the person we can thank) _____
 Other (Please Specify) _____

AGREEMENT TO PAY:

I understand that I am responsible for payment of services rendered and also am responsible for paying any co-payment and deductibles not covered by my insurance. I hereby authorize payment directly to Galina Nasakin DDS. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE: _____ DATE: _____

MEDICAL QUESTIONNAIRE

Please answer all questions and fill in blank spaces where indicated. Answers to the following questions are for our records only and will be strictly confidential.

MEDICAL HISTORY FOR: (NAME OF PATIENT)

01. Do you have a personal physician? Yes No Date of last visit: _____
 Physician's Name: _____ Phone #: _____
02. Are you currently under the care of a physician? Yes No
 Please Explain: _____
03. Do you have any metal rods, pins or implants? Yes No
04. Are you taking any prescription / over-the-counter drugs? Yes No
 Please list each one: _____
05. Do you have or have you had any of the following diseases or problems? (Please check "Y" for Yes or "N" for No)
- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No Shingles |
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Disease / Traits |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol / Drug Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack / Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Bones/Joints/Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes / Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis (TB) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer / Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Hospitalized for Any Reason | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No I smoke / use chewing tobacco |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Defect | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure | Women |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking birth control |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy / Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation / Therapy | Week #: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic / Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you nursing? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures | Other _____ |
06. Anything you would like to discuss with the dentist in private? Yes No
 Please list any serious medical condition(s) that you have ever had: _____

07. Are you allergic to any of the following:
- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No Erythromycin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Jewelry / Metals | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No Tetracycline |
- Please list any drugs / materials that you are allergic to: _____

IN CASE OF EMERGENCY:

Name Of Contact: _____ Phone Number: _____
 Name Of Contact: _____ Phone Number: _____

DENTAL HISTORY:

01. Why have you come to the dentist today? _____
02. Your current dental health is Good Fair Poor
03. Does any of the following apply? (Please check "Y" for Yes or "N" for No)
- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever taken Phen – Phen / Redux & Pondimin? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had problem with any previous dental work? |
| If Yes, When? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever experienced pain / discomfort in your jaw joint-TMJ? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do You require antibiotics before dental treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do your gums ever bleed? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you currently in pain? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are your teeth sensitive to heat, cold, or anything else? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had gum treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you like your smile? |

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.

PATIENT'S SIGNATURE: _____ DATE: _____
 DOCTOR'S SIGNATURE: _____ DATE: _____