

## **FIRST DENTAL PATIENT APPLICATION**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

PHONE: \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

E-MAIL: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ OTHER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

SPOUSE 'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

IN CASE OF EMERGENCY: \_\_\_\_\_ NUMBER: \_\_\_\_\_

### **DENTAL INSURANCE**

RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

PATIENT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

Group #: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

I \_\_\_\_\_ CERTIFY THAT I/ DEPENDENT(S) HAVE INSURANCE COVERAGE WITH: \_\_\_\_\_ ASSIGN DIRECTLY TO DR IMREK ALL INSURANCE BENEFITS, IF ANY. OTHERWISE PAYABLE TO ME FOR SERVICE RENDERED. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF SIGNATURE ON INSURANCE SUBMISSION.

### **DENTAL HISTORY**

REASON FOR VISIT TODAY: \_\_\_\_\_ FORMER DENTIST: \_\_\_\_\_

LAST DENTAL VISIT: \_\_\_\_\_ LAST DENTAL X-RAY: \_\_\_\_\_

MOUTH PAIN OR DISCOMFORT: \_\_\_\_\_ SENSITIVE TEETH: \_\_\_\_\_ BLEEDING GUMS: \_\_\_\_\_

GROWTHS: \_\_\_\_\_ OTHER: \_\_\_\_\_

DO YOU SNORE: \_\_\_\_\_ WHAT POSITION(S) DO YOU SLEEP (side back stomach) \_\_\_\_\_

DO YOU HAVE NOSE CONGESTION \_\_\_\_\_ SCALE TO 1-10 (1 BEING PERFECT 10 BEING WORST) HOW RESTED DO YOU FEEL UPON AWAKING IN THE MORNING \_\_\_\_\_ DO YOU FLOSS: \_\_\_\_\_ HOW OFTEN: \_\_\_\_\_ BRUSH (how many times a day) \_\_\_\_\_

**MEDICAL HISTORY**

- AID/HIV \_\_\_\_\_
- ANEMIA \_\_\_\_\_
- ARTHRITIS \_\_\_\_\_
- ARTIFICIAL HEART VALVES \_\_\_\_\_
- ARTIFICIAL JOINTS \_\_\_\_\_
- ASTHMA \_\_\_\_\_
- BACK PROBLEMS \_\_\_\_\_
- BLOOD DISEASE \_\_\_\_\_
- BLONE DISEASE \_\_\_\_\_
- CANCER \_\_\_\_\_
- CHEMICAL DEPENDENCY \_\_\_\_\_
- CHEMOTHERAPY \_\_\_\_\_
- CIRCULATORY PROBLEMS \_\_\_\_\_
- CONGENITAL HEART LESIONS \_\_\_\_\_
- CORTISONE TREATMENTS \_\_\_\_\_
- COUGH, PERSISTENT OR BLOODY \_\_\_\_\_
- DIABETES \_\_\_\_\_
- EMPHYSEMA \_\_\_\_\_
- RESPIRATORY DISEASE \_\_\_\_\_
- RHEUMATIC FEVER \_\_\_\_\_
- SCARLET FEVER \_\_\_\_\_
- SHORTNESS OF BREATH \_\_\_\_\_
- SINUS PROBLEMS \_\_\_\_\_
- SKIN RASH \_\_\_\_\_
- STROKE \_\_\_\_\_
- SWOLLEN FEET/ANKLES \_\_\_\_\_
- SWOLLEN NECK GLANDS \_\_\_\_\_
- THYROID PROBLEMS \_\_\_\_\_
- TONSILLITIS \_\_\_\_\_
- TUBERCULOSIS \_\_\_\_\_
- TUMOR/GROWTH HEAD/NECK \_\_\_\_\_
- TUMOR/GROWTH MOUTH \_\_\_\_\_
- ULCERS \_\_\_\_\_
- UNEXPLAINED WEIGHT LOSS \_\_\_\_\_
- VENEREAL DISEASE \_\_\_\_\_

**HAVE YOU EVER TAKEN:**

- Diet medications:** FEN-PHEN \_\_\_\_\_ LONIMIN \_\_\_\_\_ ADIPEX \_\_\_\_\_ FASTIN \_\_\_\_\_ PONDIMIN \_\_\_\_\_ REDUX \_\_\_\_\_
- Bone medications:** FOSAMAX \_\_\_\_\_ ZOMETA \_\_\_\_\_ BONIVA \_\_\_\_\_ ACTONEL \_\_\_\_\_ OTHER \_\_\_\_\_

**MEDICATIONS (including vitamins)**

\_\_\_\_\_

**ALLERGIES**

- ASPIRIN \_\_\_\_\_
- BARBITURATES \_\_\_\_\_
- CODEINE \_\_\_\_\_
- IODINE \_\_\_\_\_
- LATEX \_\_\_\_\_
- LOCAL ANESTHETIC \_\_\_\_\_
- PENICILLIN \_\_\_\_\_
- OTHER \_\_\_\_\_

I \_\_\_\_\_ CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY ABILITY.