

## Patient Information

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_  
Residence Address: \_\_\_\_\_  
SS#: \_\_\_\_\_ Employer \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_ Bus. #: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Occupation: \_\_\_\_\_ Spouse/or Closest Relative: \_\_\_\_\_  
Contact #: \_\_\_\_\_

## Dental Insurance Information

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_ Group/Policy#: \_\_\_\_\_  
Name of Subscriber \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_  
Employer \_\_\_\_\_ Is patient covered by additional insurance? \_\_\_\_\_ Yes \_\_\_\_\_ no

### Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
Name of Insurance Company

And assign directly to Dr. Olga Karnakova all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Date

## Dental History

How did you hear about our office? \_\_\_\_\_

Are you currently under the care of any other dentist? \_\_\_\_\_

Do you have your teeth cleaned regularly? \_\_\_\_\_ Where? \_\_\_\_\_

Are you unhappy with the appearance of your teeth \_\_\_\_\_ Do you think dental implants would be beneficial for you? \_\_\_\_\_

Why are you seeking dental treatment at this time? \_\_\_\_\_

What are the results you would most like to achieve? \_\_\_\_\_

Is there anything else you would like to change about your teeth or smile? \_\_\_\_\_

Have you ever teeth whitened? \_\_\_\_\_ Are you interested in teeth whitening? \_\_\_\_\_

# Health Questionnaire

Are you in good health? \_\_\_\_\_ Have you been under the care of a physician during the last 3 years? \_\_\_\_\_  
 Please describe: \_\_\_\_\_  
 Date of last visit: \_\_\_\_\_ Name of personal physician: \_\_\_\_\_  
 Physician address/Telephone: \_\_\_\_\_

Please list any other treating physicians;  
 Name \_\_\_\_\_ Phone: \_\_\_\_\_ Address \_\_\_\_\_  
 Name \_\_\_\_\_ Phone: \_\_\_\_\_ Address \_\_\_\_\_  
 Person to contact in case of emergency \_\_\_\_\_ Phone: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

## Social History Lifestyle

Do you smoke? \_\_\_\_\_ How much do you smoke? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_  
 Do you use "smokeless" tobacco? \_\_\_\_\_ Do you use alcohol? \_\_\_\_\_  
 How many drinks per week? \_\_\_\_\_ Do you use recreational drugs? \_\_\_\_\_  
 What type? \_\_\_\_\_ Last recreational drug used? \_\_\_\_\_

## General Health History

- |  |  |
|--|--|
| <p>AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Colitis/Intestinal Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cortizone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough/persistent <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy/seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting/dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart or Bypass Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis A,B,C <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pacemaker/or Implanted Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tumor or growth on head or neck <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight Loss, unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Implants or surgical screws <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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### Women:

Are you pregnant?  Yes  No      Taking birth control pills?  Yes  No      Are you nursing?  Yes  No

## Medications

Please list all the medications you are presently taking Medications:	including any herbal and dietary supplements: Purpose:

Please list all major surgeries or hospitalizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies:**     Aspirin     Barbiturates (sleeping pills)     Codeine     Iodine     Latex

Local Anesthetic     Penicillin     Sulfa     Other \_\_\_\_\_

Do you wear contact lenses?     Yes     No

## Dental History

<p>Bad breath                    <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding gums                <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blisters on lips/mouth      <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Burning sensation on tongue                    <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chew on one side</p> <p>Of mouth                      <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cigarette pipe/cigar</p> <p>Smoker                        <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clicking or popping</p> <p>Jaw                             <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry Mouth                    <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fingernail biting             <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Food collection between Teeth                         <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Foreign objects              <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Grinding teeth                <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Gums swollen/tender      <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaw pain/tiredness         <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lip/cheek biting             <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loose teeth/broken fillings                      <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mouth breathing            <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mouth pain/brushing      <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Orthodontic treatment    <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain around ear             <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Periodontal treatment     <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to cold         <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to heat         <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to sweets       <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to biting        <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sores/growths mouth                        <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How often do you floss? _____</p> <p>How often do you brush? _____</p>
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***To the best of my knowledge, all the above answers are true and correct. If I have any changes I will inform the dentist or hygienist at my next appointment.***

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**Signature** **Date**

*(To be completed by dentist)*

**Vital signs:**  
Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Date \_\_\_\_\_

ASA Classification: ASA I \_\_\_\_\_ ASA II \_\_\_\_\_ ASA III \_\_\_\_\_ ASA IV \_\_\_\_\_

**Dentist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_