Welcome from the "Gum Doctor" - Matthew Zale, D.M.D. Please complete the following important information.

PATIENT INFORMATION

patient name _____

address _____ Apartment _____

city _____ state____ ZIP_ _ _ _ _

gender...male / female AGE: _____years

date of birth mo / day /yr____

social security number _ _ _ - _ _ - _ _ _ _

Occupation _____

EMPLOYER _____

EMPLOYER address _____

EMPLOYER phone (570) _ _ _ - _ _ _ _ ext _ _ _

SPOUSE'S *name* _____

SPOUSE'S birth date _____

SPOUSE'S social security number _ _ _ - _ _ - _ _ _ _

SPOUSE'S employer _____

DENTAL INSURANCE *one choice*

Who is the subcriber listed on the dental insurance policy ?

Relationship to patient.....self _ .....spouse _ .....dependent _

Dental Insurance company _____

Insured's Identification Number _____

Insurance GROUP number _____

f benefits: dates ____ to ____ or calender year.

se covered by ADDITIONAL insurance? ...Yes..No...

If yes, list Subscriber name _____

Subscriber date of birth mo / day /yr___

Subscriber social security # _ _ _ - _ _ - _ _ _ _

Subscribers business address _____

Subscriber INSURANCE company _____

GROUP number _____

Period of benefits: dates from____to____.

Fee for service is due at time procedure is performed.

PHONE NUMBERS

A. **home** phone (570) _ _ _ - _ _ _ _ *unlisted ?*

B. **work** phone (570)_ _ _ - _ _ _ _ extension #_____

C. Best time and place to call_____

D. *In the event of an emergency, call: (specify someone who does NOT live in your household).*
name _____ *phone* (570) _ _ _ - _ _ _ _ *relationship* _____

E. Pager phone # _ _ _ - _ _ _ _

F. Cellular phone # _ _ _ - _ _ _ _

G. SPOUSE'S work number (570) _ _ _ - _ _ _ _

DENTAL TREATMENT HISTORY

Fill-in or ◯ *choose one ..yes..no.or.don't know..*

1. Date of last dental visit? _____ Reason for last visit _____
2. Date last X'Ray (radiograph) __/__ Last full set (14 X-Rays) ? __/__
3. Date of last teeth cleaning (prophylaxis) ___/___..... Scaling __/__
4. Do you already have an appointment for a dental cleaning ? yes no
5. Are your teeth very sensitive to hot or cold food ? yes no
6. Have you ever had gum surgery ? yes no If yes when? _____
7. Did you bleed excessively after surgery ? yes no
8. Have you had orthodontics ("braces")? yes no If yes when?____
9. Are you experiencing dental discomfort (pain) at this time? yes no
10. If you have pain where is it ?..upper / lower... front /back.... right /left..
When does pain occur ? .....eating....sleep...talk.....always
For how long has it been hurting ? _____months.
11. Do you have dental implants (titanium) at this time ? yes no
12. Do you have frequent headaches ? yes no
13. Have your teeth "moved" during the last year ? yes no
14. Do your teeth feel very different in the morning ? yes no
15. Date of last dental crown (tooth "cap")_____ Which tooth?____
16. Date of last root canal _____ Which tooth?_____
17. Do you use tobacco ? ...yes...no How much per day?_____
18. Amount of alcohol consumed daily, #_____ *(8 oz) drinks /day*

What is the reason for your visit today ? _____

PATIENT HEALTH HISTORY any of the following which you had or have at present:

	y	n	dk
Aids or HIV infection			
Anemia			
Arthritis			
Artificial heart valve			
Asthma			
Bleeding abnormality			
Cancer			
Chemical dependency			
Circulatory problems			
Cortisone treatment			
Diabetes			
Emphysema			
Fainting or dizziness			
Epilepsy			
Glaucoma			
Headaches			
Hearing Aide in ear			

	y	n	dk
Heart murmur			
Heart problems			
Hepatitis A,B or C			
Herpes			
High blood pressure			
Hip or joint replacement			
HIV Positive			
Jaundice			
Jaw Pain			
Kidney disease			
Liver Disease			
Low blood pressure			
Mitral Valve prolapse			
Nervous problem			
Pacemaker			
Psychiatric care			
Radiation treatments			

	y	n	dk
Respiratory disease			
Rheumatic Fever			
Scarlet Fever			
Tumor or growth (head or neck)			
Shortness of breath			
Sinus problems			
Skin rash			
Special Diet			
Swelling of feet or ankles			
Swollen neck glands			
Thyroid problems			
Tuberculosis (TB)			
Ulcers			
Venereal Disease (VD)			
Weight Loss, unexplained.			
Wear Contact (eye) lenses			

1. Do you have any **other problem** or condition, which is NOT identified above? ***...yes .. no.. or.. don't know.. .***
   If yes, please explain _____

2. Has a physician said you have an **allergy** *to codeine, erythromycin, latex, nickel (metals) Novocain, penicillin, or other things*?
   ....Yes....no....don't know... If yes, please explain, including the date of diagnosis _____.
   _____

3. List all current **medications**: *such as antacids, anti-depressants, blood "thinners", aspirin, diet supplements, steroids, or others?*

A.	____MG per day	D.	____MG per day
B.	____MG per day	E.	____MG per day
C.	____MG per day	F.	____MG per day

[***pharmacy*** *Name* _____ *location: (street,city)* _____ *phone number* _____-_____]

It is important to list all current medications and drugs, in order to prevent side effects of drug interactions. Some drug interactions can cause serious health problems.

4. Have you recently stopped any medications or drugs ? yes no If yes, please explain.
   _____

5. Were you admitted to a **hospital** during the previous 12 months ? yes no If yes, please explain.
   _____

6. *Name of* ***physician*** *who knows you best* _____ *M.D. Address of physician: City* _____

7. *When was the last medical visit to this physician* _____. ? *Reason for visit*_____

8. If you see a medical Specialist, who is he/she _____

9. **Women**: are you now pregnant or nursing ? ..yes...no...*(Do not write "")* If yes, what is the "due date" or birth date _____

10. *Please write name and location of your* ***General Dentist*** _____.

patient signature *All the above information is accurate and is to be kept confidential.*

X - date- - - - - -

Please do not write below this line. .....Office use only

Reviewer of the above information :

Staff initial	*Note changes by section*	*Pat. Inital*	*date*

staff initials	*Note changes by section*	*Pat. Inital*	*date*