Patient Information

NAME _____ ( ) _____ ( ) _____
(Last) (First) (Middle) Home Ph. # Cell Ph. #

LOCAL ADDRESS _____
(City) (Zip)

OUT OF TOWN ADDRESS _____
(City/State) (Zip)

OCCUPATION _____ E-MAIL ADDRESS _____

DATE OF BIRTH _____ SEX _____ HEIGHT _____ WEIGHT _____

MARITAL STATUS (CIRCLE) SINGLE MARRIED SOCIAL SECURITY NO. _____

SPOUSE'S NAME _____ SPOUSE'S OCCUPATION _____

PERSON RESPONSIBLE FOR ACCOUNT _____ ADDRESS _____

HOBBIES/INTERESTS _____

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE PREVIOUSLY? YES NO

DENTAL INSURANCE _____ WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHY DID YOU CHOOSE DR. KOMETAS AS YOUR DENTIST? _____

REASON FOR VISIT _____

Dental Health (please check): EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑

On a scale of 1-10 (10 being highest) what priority do you give your teeth? 1 2 3 4 5 6 7 8 9 10

MEDICAL HEALTH

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionniare and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your permission.

General Health (please check): EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑:

Name and address of Physician _____

Last complete physical? _____

Are you taking any medication now? Yes ❑ No ❑ For what purpose? _____

Please list all medications: _____

CHECK ANY CONDITION YOU HAVE HAD, MAY HAVE, OR HAVE BEEN TREATED FOR:

- ❑ Heart Disease
  - ❑ Angina
  - ❑ Arrythmia
  - ❑ Congenital Heart Lesions
  - ❑ Heart Murmur
  - ❑ Mitral Valve Proiapse
  - ❑ Rheumatic Fever
  - ❑ Stroke
- ❑ Emphysema
- ❑ Cough
- ❑ Tuberculosis
- ❑ Other Respiratory Problems
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Acquired Immune Deficiency Syndrome
- ❑ Ulcers
- ❑ Arthritis
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Thyroid Problems
- ❑ Bleeding Problems
- ❑ Have you ever had a blood transfusion?
- ❑ Cancer
- ❑ Abnormal Blood Pressure
- ❑ Blood Diseases
- ❑ Anemia
- ❑ Sinus Trouble

Other medical problems not listed above? _____

Have you ever been treated for osteoporosis? Yes ❑ No ❑

If yes, please list all medications... _____

Do you have any hip or joint replacements? Yes ❑ No ❑

Have you ever been treated (other than diagnostic) with x-ray? Yes ❑ No ❑

Are you allergic to: Penicillin ❑ Codeine ❑ Local anesthetics ❑ Other medications ❑

Are you subject to prolonged bleeding Yes ❑ No ❑ Are you subject to fainting spells? Yes ❑ No ❑

Are you pregnant? Yes ❑ No ❑ How Long? _____

I will allow Dr. Kometas to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures, and further allow his permission to discuss my conditions with my physician and to request medical information form him/her. Yes ❑ No ❑

WE SHALL ENDEAVOR TO MAKE YOUR VISITS AS CONVENIENT AND PLEASANT AS POSSIBLE. IF AT ANY TIME YOU HAVE ANY QUESTIONS REGARDING YOUR TREATMENT, APPOINTMENTS, OR FEES, PLEASE ASK.

SIGNATURE _____ DATE _____