

PATIENT MEDICAL HISTORY

Name: _____ Date _____

Name and phone of physician: _____

Preferred Pharmacy name and phone: _____

- | | <u>Yes</u> | <u>No</u> |
|---|------------|-----------|
| 1. Have you ever been told you need to take an antibiotic premedication before dental work? | _____ | _____ |
| 2. Have you been hospitalized during the past two years? | _____ | _____ |
| 3. Are you allergic to or made sick by penicillin, aspirin, codeine or other medications?
list: _____ | _____ | _____ |
| 4. Are you taking any medications now? (Aspirin, antibiotics, etc...) | _____ | _____ |
| 5. Please list medications: _____ | | |
| <hr/> | | |
| 6. Are you subject to prolonged bleeding? | _____ | _____ |
| 7. When you walk up stairs or take a walk, do you have to stop because of chest pain, shortness of breath or fatigue? | _____ | _____ |
| 8. Have you gained or lost more than 10 pounds in the past year? | _____ | _____ |
| 9. Have you or your family member ever been diagnosed with oral, head or neck cancer? | _____ | _____ |
| 10. For women only: Are you now or do you anticipate becoming pregnant?
Are you using birth control? | _____ | _____ |
| 11. Do you smoke cigarettes or chew tobacco? How much? | _____ | _____ |
| 12. Do you currently have or have you been treated for: (circle any that apply) | | |

- | | | |
|------------------------------------|---------------------------|--------------------------------------|
| mitral valve prolapse | emphysema | HIV (AIDS virus) |
| congestive heart failure | persistent cough | Hepatitis A |
| heart disease or heart attack | tuberculosis (TB) | Hepatitis B or C |
| rheumatic heart disease | lung disease | liver disease/ or transplant |
| high blood pressure, or abnormal | asthma | yellow jaundice |
| heart murmur | allergies or hives | blood transfusion |
| congenital heart defect/ condition | diabetes | drug addiction, alcoholism |
| heart pacemaker/ defibrillator | thyroid disease | STD (sexually transmitted disease) |
| artificial heart valve or stent | chemotherapy or radiation | Cold sores |
| cardiac transplant | arthritis | Temporal mandibular joint pain (TMJ) |
| stroke | joint replacement | Epilepsy or seizures |
| anemia | fibromyalgia | Fainting or dizzy spells |
| history of infective endocarditis | headaches | Psychiatric treatment |
| kidney problems/ or transplant | glaucoma | ulcers |
| cancer | lupus | |

15. Do you have any disease, conditions or problem not listed? _____

DENTAL HISTORY

1. Are you having a dental problem now? _____ Describe: _____
2. How long has it been since your last appointment in a dental office? _____
3. What treatment was performed at that time? _____
4. Do you usually have local anesthetic for fillings? _____ Nitrous Oxide? _____
5. How many times a day do you brush your teeth? _____ floss: _____ other dental aids: _____
6. Have you had dental xrays? _____ Do you have any missing teeth? _____ Cause: _____
7. If you have had extraction(s), did you have any complications? _____
8. Have you had missing teeth replaced with a fixed bridge? _____ removable partial? _____ denture? _____
9. Have you had dental orthodontic treatment? _____ date: _____
10. Are your teeth sensitive to heat? _____ cold? _____ sweets? _____
11. Do your gums bleed when brushing? _____ Do you notice bad breath or bad taste? _____
12. Have you had gum tissue (periodontal) treatment? _____ date: _____
- 13 Do you grind or clench your teeth? ____ 14. Do you have history of TMJ trauma? ____ Clicking/Popping? ____ Pain ____
15. Are you fearful of having dental care? _____ How do you value your teeth? _____

To the best of my knowledge, all of these answers are correct. If there is any change in my health or my medications, I will inform Dr. Litvinov or his staff at my next appointment. I hereby authorize Dr. Alan Litvinov and his team to perform dental treatment which may include the use of local anesthesia, nitrous sedation, x-rays or diagnostic tests. I understand that, though good results are expected, the possibility and nature of complications such as swelling, infection, discoloration of the face or neck, bruising, muscle or TMJ soreness, difficulty swallowing cannot always be accurately anticipated.

(Patient signature) (date)

(Doctor's signature) (date)

Alan Litvinov, D.D.S
126 Jackson Road Extension
Penfield, NY 14526

PATIENT REGISTRATION

Patient Name: _____ Today's Date: _____

Date of birth: _____ Age: _____ Male/Female: _____ Social Security Number: _____-_____-_____

Address: _____ City _____ St _____ Zip _____

Home Phone Number: (____) _____ Work Phone Number: (____) _____

Cell Phone number: (____) _____

Status (Circle One): Single, Married, Divorced, Separated, Widowed

Email Address _____

Employer Name and Address: _____

Present Position _____

Whom may we thank for referring you? _____

Name of Spouse, Parent or Custodian: _____

Date of birth: _____ Age: _____ Male/Female: _____ Social Security Number: _____-_____-_____

Email address: _____

Home Phone Number: (____) _____ Work Phone Number: (____) _____

Spouse's Employer Name and Address _____

Emergency Contact Person _____

Emergency Contact's Address _____

Emergency Contact's Home Phone Number: (____) _____

Emergency Contact's Work Phone Number: (____) _____

Primary Dental Insurance Co: _____

(Name) (Address)

Name of Policy Holder: _____ Group or ID #: _____

Secondary Dental Insurance Co: _____

(Name) (Address)

Name of Policy Holder: _____ Group or ID #: _____

Person Responsible for this Account: _____

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Signature of Patient, Parent or Guardian: _____ Date: _____