Dr. Paul Deratnay & Associates welcome you

Personal Information

Mr.___ Mrs.___Miss.___Ms.___Dr.___ Last Name: _____First Name: _____ Male__ Female____

Prefer to be called: _____ D.O.B: *Month* _____*Day* _____*Year* _____

Address: _____ City: _____Postal Code: _____

Phone #: _____ (work)_____ email: _____

Employer: _____ Occupation: _____

Email: _____ Referred by: _____

Family Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Insurance

Primary Plan holder name:

Last:_____First:_____

D.O.B: _____Policy: _____

Insurance Co: _____

Subscriber ID: _____

Secondary Insurance cardholder name:

Last:_____First:_____

D.O.B: _____ Policy: _____

Insurance Co: _____

Subscriber ID: _____

Medical History

Do you have any of the following?

- ☐ Heart Murmur / Mitral valve prolapse / irregular heartbeat
- ☐ Pacemaker
- ☐ Stroke
- ☐ Artificial Heart Valve
- ☐ Low blood pressure
- ☐ High Blood pressure
- ☐ Bleeding / Clotting disorder
- ☐ Joint replacements (hip/knee)
- ☐ Lung disease
- ☐ COPD
- ☐ Kidney disease
- ☐ Diabetes: type 1 / type 2
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Thyroid
- ☐ Stomach ulcers
- ☐ Osteoporosis
- ☐ Crohn's disease
- ☐ Irritable bowel
- ☐ Ulcerative colitis
- ☐ Herpes
- ☐ Facial pain disorder
- ☐ Epilepsy
- ☐ Cancer
- ☐ HIV / AIDS
- ☐ Hepatitis
- ☐ Drug / Alcohol Dependency
- ☐ Liver Disease

Please list any other conditions not listed above:

_____

_____

Please list any medications you are taking:

_____

_____

_____

Do you have any allergies? Yes No

Please list: _____

_____

Do you require Pre-Medication before any dental work? _____Yes / No

Any prior radiation treatment to head or neck? If so, when? _____

When was your last dental cleaning?_____

How often do you brush your teeth? _____ Floss? _____

Do you have any dental concerns? Yes / No _____

Are your teeth sensitive to hot, cold, sweets, or to biting? _____ Yes / No

Do you snore or have obstructive sleep apnea? Yes / No …Do you currently wear a night guard? Yes / No / Sometimes

Do you suffer from headaches/migraines? _____Yes / No

Do you smoke? How much per day? _____ Yes / No

Do you bruise easily or bleed abnormally? _____Yes / No

Do your gums bleed easily? _____ Yes / No

Do you have jaw pain? _____ Yes / No

Have you ever had jaw surgery? _____ Yes / No

Do grind or clench your teeth? _____ Yes / No

For women, are you pregnant? _____ Yes / No

Are you currently breastfeeding? _____ Yes / No

The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set up and monitored by our office.

I acknowledge that I have completed the medical history to the best of my knowledge. I am aware of the office cancellation policy, which requires a patient to provide 48 hours' notice to cancel an appointment to avoid a cancellation fee.

Signature: _____ *Date:* _____

Parent or guardian name: _____ *Date:* _____