

# Aaron Elkowitz, DMD, P.C.

Date: \_\_\_\_\_

## Patient Information

Name: Dr. Mr. Mrs. Miss \_\_\_\_\_  
Circle One First Name Middle Initial Last Name

Address: \_\_\_\_\_  
Number & Street City State Zip Code

Phone: \_\_\_\_\_  
Home# Work# Fax#

\_\_\_\_\_ Cellular Phone E-mail Address

\_\_\_\_\_ Date of Birth Social Security No. Driver's License No. & State

\_\_\_\_\_ Occupation Sex Marital Status Name of Spouse

\_\_\_\_\_ Closest Relative(Other than spouse) Phone Number Relationship

\_\_\_\_\_ Responsible Party of Account Address (If different from above) Relationship

\_\_\_\_\_ Insurance Carrier Group Number Relationship to Insured

\_\_\_\_\_ Employer Employer Address

\_\_\_\_\_ Referred By

## DENTAL HISTORY

Circle One

- |  |     |    |
|--|-----|----|
| 1. Are you having any specific problems with your teeth, gums, or mouth?                           | Yes | No |
| 2. Are your teeth sensitive to hot, cold, or sweets?   | Yes | No |
| 3. Do your gums bleed after brushing; are they often sore or tender?                               | Yes | No |
| 4. Do you have any difficulty chewing your food?   | Yes | No |
| 5. Do you have any or frequently get fever blisters, mouth ulcers, or sores on your lips or mouth? | Yes | No |
| 6. Do you often have chapped lips, cracked or raw places on corners of your mouth?                 | Yes | No |
| 7. Do you frequently get food wedged between your teeth?   | Yes | No |
| 8. Have you ever worn braces or a retainer for straightening your teeth?                           | Yes | No |
| 9. Do you smoke or chew tobacco in any form?   | Yes | No |
| 10. Are you unhappy with the appearance of your teeth?   | Yes | No |
| 11. Do you clench or grind your teeth?   | Yes | No |
| 12. Do you notice clicking, popping, or soreness of the jaws or points just in front of the ears?  | Yes | No |
| Which Side? Left or Right (Circle)   |     |    |
| 13. Do you ever have frequent headaches, earaches, stiffness, or soreness in your neck?            | Yes | No |
| 14. When was your last dental check-up? _____  |     |    |
| 15. When were your teeth cleaned last? _____   |     |    |
| 16. When were your last set of dental x-rays? _____  |     |    |

## MEDICAL HISTORY

Circle One

- |   |     |        |
|---|-----|--------|
| 1. Are you in good health?  | Yes | No     |
| 2. Has there been any change in your general health within the past year?   | Yes | No     |
| 3. Are you now under the care of a physician?<br>If so, what is the condition being treated?                            | Yes | No     |
| 4. The name and address of my physician is: _____<br>_____<br>_____   |     |        |
| 5. When was your last physical examination?   |     |        |
| 6. Have you had any serious illness or operation?<br>If so, what was the illness or operation?                          | Yes | No     |
| 7. Have you been hospitalized or had a serious illness within the past 5 years?<br>If so, what was the problem? _____   | Yes | No     |
| 8. Do you have or have you had any of the following diseases or problems?   |     |        |
| a. Damaged heart valves, artificial heart valves, or <b>Mitral Valve Prolapse</b> ?                                     | Yes | No     |
| b. Congenital heart lesions?  |     | Yes No |
| c. Cardiovascular disease(heart trouble, heart attack, coronary disease, high blood pressure, arteriosclerosis, stroke) |     | Yes No |
| 1) Do you have chest pain upon exertion?  |     | Yes No |
| 2) Are you ever short of breath after mild exercise?  | Yes | No     |
| 3) Do your ankles swell?  |     | Yes No |
| 4) Do you get short of breath when you lie down, or do you require an extra pillow when you sleep                       |     | Yes No |
| 5) Do you have a cardiac pacemaker?   |     | Yes No |
| d. ALLERGIES: i.e. LATEX, NICKEL, SILVER  |     | Yes No |
| e. Sinus trouble?   |     | Yes No |
| f. Asthma or hay fever?   |     | Yes No |
| g. Hives or a skin rash?  |     | Yes No |
| h. Fainting spells or seizures?   |     | Yes No |
| i. Diabetes?  |     | Yes No |
| 1) Do you have to urinate (pass water) more than six times a day?   |     | Yes No |
| 2) Are you thirsty much of the time?  |     | Yes No |
| 3) Does your mouth frequently become dry?   |     | Yes No |
| j. Hepatitis, jaundice, or liver disease?   |     | Yes No |
| k. Arthritis or Inflammatory rheumatism (painful swollen joints)?   | Yes | No     |
| l. Do you have any artificial joints(i.e. hips, knees, elbows)  |     | Yes No |
| m. Stomach ulcers?  |     | Yes No |
| n. Kidney trouble or disease?   |     | Yes No |
| o. Tuberculosis (T.B.)?   |     | Yes No |
| p. Do you have a persistent cough or cough up blood?  |     | Yes No |
| q. Low blood pressure?  |     | Yes No |
| r. Venereal disease?  |     | Yes No |
| s. AIDS or HIV infection?   |     | Yes No |
| t. Other?   |     |        |
| 9. Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma?                        | Yes | No     |
| a. Do you bruise easily?  | Yes | No     |
| b. Have you ever required a blood transfusion?<br>If so, explain the circumstances?                                     | Yes | No     |
| 10. Do you have any blood disorder such as anemia?  | Yes | No     |
| 11. Are you allergic or have you reacted adversely to:  |     |        |
| a. Local anesthetics?   | Yes | No     |
| b. Penicillin or any other antibiotic?  | Yes | No     |
| c. Sulfa Drugs?   | Yes | No     |
| d. Barbituates, sedatives, or sleeping pills?   | Yes | No     |
| e. Aspirin, ibuprofen, or acetaminophen?  | Yes | No     |
| f. Iodine?  | Yes | No     |
| g. Codine or any other narcotic?  | Yes | No     |
| h. Other:   |     |        |

**Circle One**

12. Are you taking any of the following types of medications:

- |  |     |     |    |
|--|-----|-----|----|
| a. Antibiotics or sulfa drugs?                     |     | Yes | No |
| b. Anticoagulants (blood thinners)?                |     | Yes | No |
| c. Medicine for high blood pressure?               |     | Yes | No |
| d. Cortisone (steroids)?                           |     | Yes | No |
| e. Tranquilizers?                                  |     | Yes | No |
| f. Antihistamines?                                 |     | Yes | No |
| g. Aspirin?  |     | Yes | No |
| h. Insulin, tolbutamide (Orinase) or similar drug? | Yes | No  |    |
| i. Digitalis or drugs for heart trouble?           |     | Yes | No |
| j. Nitroglycerin?                                  |     | Yes | No |
| k. Oral contraceptive or other hormonal therapy?   |     | Yes | No |

13. Please list all medications and the dose you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____

14. Do you use any tobacco products? Yes No  
 If so, how much per day and what?

15. Do you use any alcoholic products? Yes No  
 If so, how much per day/week/month and what?

16. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? Yes No

17. Are you wearing contact lenses? Yes No

18. Do you have any disease, condition, or problem not listed above? Yes No  
 If so, please explain: \_\_\_\_\_

**WOMEN**

19. Are you pregnant? Yes No

20. Do you have any problems associated with your menstrual period? Yes No

21. Are you nursing? Yes No

22. Are you taking oral contraceptives? Yes No

I certify that I have read the above questions and answered them to the best of my ability. I acknowledge that my questions about the inquiries set forth above have been answered to my satisfaction. I will not hold Aaron Elkowitz, DMD,P.C., or any other member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

I understand that I am responsible for my account, regardless of any insurance plan I may have. Payment for services is due at the time services are rendered with the exception when payment arrangements have been approved in advance by our staff. We accept cash, checks, Mastercard, and Visa. Finance charges of 1 1/2%per month will be applied to accounts over 60 days and in the event of default to pay reasonable collection charges and/or attorney fees.

\_\_\_\_\_  
 Signature of Patient or Responsible Party

\_\_\_\_\_  
 Date

**For completion by the Dentist.**

