

Name _____ Date of Birth _____ Age _____
 Preferred Name (Name by which you would like us to address you) _____
 Home Address _____ Email Address _____
 Home Phone _____ Business Phone _____ Cell _____
 Which telephone would be best for messages? _____ Social Security # _____
 Occupation _____ Marital Status S M W D Spouse's Name _____
 Emergency Phone Number and contact person _____
 Whom may we thank for referring you to our practice? _____
 Your Dentist's Name _____ Address _____
 _____ Phone _____
 Your Physician's Name _____ Address _____
 _____ Phone _____
 Date of last Exam _____ Findings? _____
 What is your present problem and what would you like to have handled today? _____

Dental Insurance

So that we may assist you in submitting dental insurance claims, please complete ALL of the following information:

PrimaryHolder _____ DOB ___/___/___ SS# _____ EmployerName _____
 Address _____ Insurance Carrier _____ Group# _____
 Insurance Co. Address _____ Phone _____
 SecondaryHolder _____ DOB ___/___/___ SS# _____ EmployerName _____
 Address _____ Insurance Carrier _____ Group# _____
 Insurance Co. Address _____ Phone _____

Medical History

These questions all have relevance to your oral health. They will help and protect you. Please complete each item.

1. Have you been hospitalized in the past? Yes No
 Why? _____
2. Have you been under the care of a medical doctor in the past 5 years? Yes No
 Why? _____
3. Have you been sick in the past 3, 6, 9, 12 months? Yes No
4. Have you taken any medicine or drugs in the past 2 years? Yes No
 What? _____
4. Do you take aspirin daily or any nutritional supplements or vitamins?..... Yes No
5. What? _____
6. Are you allergic to, or made sick by any medication or drug? Yes No
 What? _____
7. Have you ever had excessive bleeding requiring special treatment? Yes No
8. Have you ever been told to take antibiotics before dental care?..... Yes No

PLEASE COMPLETE THE REVERSE SIDE

9. Circle any of the following which you have had or do have.

- | | | |
|-------------------------|-------------------------------|--------------------------|
| Heart Failure | Emphysema | HIV |
| Heart Disease or Attack | Cough | Hepatitis A |
| Angina Pectoris | Tuberculosis (TB) | Hepatitis B (Serum) |
| High Blood Pressure | Asthma | Liver Disease |
| Heart Murmur | Hay Fever | Yellow Jaundice |
| Rheumatic Fever | Sinus Trouble | Blood Transfusion |
| Congenital Heart Lesion | Allergies or Hives | Drug Addiction |
| Scarlet Fever | Diabetes (also in the family) | Hemophilia |
| Artificial Heart Valve | Thyroid Disease | Venereal Disease |
| Heart Pacemaker | X-Ray or Cobalt Therapy | (Syphilis, Gonorrhea) |
| Heart Surgery | Chemotherapy | Cold Sores |
| Artificial Joints | Cancer, Leukemia | Herpes |
| Anemia | Arthritis | Epilepsy or Seizure |
| Stroke | Rheumatism | Fainting or Dizzy Spells |
| Kidney Trouble | Glaucoma | Psychiatric Treatment |
| Ulcers | Cortisone Medication | Nervousness |
| Pain in Jaw Joints | Bruise Easily | Sickle Cell Disease |
| Mitral Valve Prolapse | Alcoholism | Canker Sores |

Other _____

10. Do you have chest pain, shortness of breath or loss of strength walking upstairs? Yes No
11. Do your ankles swell during the day? Yes No
12. Have you lost or gained more than 10 pounds in the past year? Yes No
13. Are you on a special diet? Yes No
14. Do you have any disease or problem not listed? Yes No
15. Women: Are you or might you be pregnant now or anticipate becoming pregnant? Yes No
Are you taking birth control pills or any hormone medication? Yes No
16. Have you had recent life events that have resulted in stress or tension? Yes No
17. Do you smoke? Yes No - How much? _____
18. Do you exercise with any regularity? Yes No
19. Have you ever taken Fosamax (Alendronate), Actonel (Risedronate), Binovia (Ibandronate), Aredia (Pamidronate), Zometa (Zoledronate), Skleid (Tiludronate), Etidronate (Didronel), Fen-phen? Yes No
If yes, when did you start the medication? _____
20. Have you ever had breast cancer, prostate cancer or multiple myeloma and been treated for the spread of these cancers to the bone or have you ever had Paget's disease? Yes No

Comments _____

1. To the best of my knowledge, all of the answers I have given on this form are true and correct. If I ever have a change in my health, or if my medications change, I will inform Dr. Scharf at my next visit.
2. I authorize Dr. Scharf or designated staff to take models, x-rays, photographs or any other diagnostic materials deemed appropriate by Dr. Scharf to diagnose and document my oral condition. I understand that Dr. Scharf lectures nationally and internationally and is actively involved in publication. I consent to the use of these materials for teaching or publication purposes and understand that my identity will be protected.
3. Upon such diagnosis, I authorize Dr. Scharf to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care.

Date _____ Signature _____

Reviewed By _____ D.M.D Date _____