

# CONGRESS DENTAL GROUP

Welcome!

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

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as possible. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## Patient Information

Whom may we thank for referring you? \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
 Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female  
 Address: \_\_\_\_\_ Marital Status:  Married  Separated  Widowed  Divorced  Single  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Patient Occupation: \_\_\_\_\_ Patient Employer/School: \_\_\_\_\_  
 Employer/School Address: \_\_\_\_\_ Employer/School Phone: (\_\_\_\_) \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
 Spouse's Occupation: \_\_\_\_\_ Spouse's Employer/School: \_\_\_\_\_  
 Spouse's Birth date: \_\_\_\_\_ Spouse's Age: \_\_\_\_\_ Patient Employer/School: \_\_\_\_\_  
 In case of emergency who should be notified? \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Alt Phone: (\_\_\_\_) \_\_\_\_\_

## Dental Insurance Information

Insurance Company Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Who is the subscriber for this account? \_\_\_\_\_ What is their relationship to the patient? \_\_\_\_\_  
 What is the subscriber's birth date? \_\_\_\_\_  
 Is the patient covered by additional insurance?  Yes  No  
 Insurance Company Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Who is the subscriber for this account? \_\_\_\_\_ What is their relationship to the patient? \_\_\_\_\_  
 What is the subscriber's birth date? \_\_\_\_\_

## Assignment and Release

I certify that I, and/or my dependents(s), have insurance coverage with \_\_\_\_\_ (name of insurance company) and assign directly to **Bob Pajoohi DMD PC / Congress Dental Group** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
 (signature of patient, parent, guardian or personal representative) \_\_\_\_\_  
 (relationship to patient)  
 \_\_\_\_\_  
 (printed name of patient, parent, guardian or personal representative) \_\_\_\_\_  
 (date)

## Today's Visit

What is the reason for today's visit? \_\_\_\_\_  
 What are your present dental concerns? \_\_\_\_\_  
 Who was your previous dentist? \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 When was your last dental visit? \_\_\_\_\_ last dental x-rays? \_\_\_\_\_ last dental cleaning? \_\_\_\_\_  
 Have you avoided regular dental care in the past? If so, why? \_\_\_\_\_  
 What are your dental expectations? \_\_\_\_\_  
 How would you rate your previous overall experiences with dental care?  Positive  Neutral  Negative  
 How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_  
 Do you use any other cleaning aid? How often? \_\_\_\_\_  
 Are you happy with the appearance of your teeth?  Yes  No Are you happy with the appearance of your gums?  Yes  No  
 Would you like your teeth to be whiter?  Yes  No Would you like your teeth to be straighter?  Yes  No

## Dental History

Please place a mark on "yes" or "no" to indicate if you have experienced any of the following:

Active decay	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen or tender gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth sores or growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal (gum) treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain from brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around the ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gum disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Foreign Objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## Health History

Who is your current physician? \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Please place a mark on "yes" or "no" to indicate if you have experienced any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally		Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen feet or ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen neck glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor	
Congenital heart lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent or bloody cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses?  Yes  No

Is there anything else we should know? \_\_\_\_\_

WOMEN - Are you pregnant?  Yes  No Due date: \_\_\_\_\_ Are you nursing?  Yes  No Are you taking birth control pills?  Yes  No

## Medications

List any medications you are currently taking and the correlating diagnosis. (If none, please write "none.") \_\_\_\_\_

## Allergies

Aspirin	Iodine	Penicillin
Barbiturates (sleeping pills)	Latex	Sulfa
Codeine	Local anesthetic	
Other? (If none, please write "none.") _____		

By my signature below, I certify that I have read each of the above questions and that all of the information herein is correct to the best of my knowledge. I hereby certify that I have answered each of these questions truthfully, accurately and as completely as possible.

\_\_\_\_\_  
(signature of patient, parent, guardian or personal representative)

\_\_\_\_\_  
(relationship to patient)

\_\_\_\_\_  
(printed name of patient, parent, guardian or personal representative)

\_\_\_\_\_  
(date)