Medical History

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

Warmly,

Allen Berman DDS, Michael Berman DDS and our Excellent Staff

Patient Information

Name (Last, First, Middle Initial)_____

Date_____ Home Phone (___)_____Cell Phone (____)_____

Email address _____SSN # _____

Address_____ City_____

State_____ Zip_____ Sex (circle one) M F Birthdate (xx/xx/xxxx)_____

Marital Status (circle one) Married Widowed Single Separated Divorced Partnered Minor

Occupation_____ Patient Employer/School_____

Employer/School Address_____ Employer/School Phone(___)_____

Whom may we thank for referring you?_____

Emergency contact _____ Relation to you _____ Phone (____)_____

Primary Insurance

Person Responsible for Account (Last, First, Middle Initial) _____

Relation to Patient _____ Birthdate _____ SSN # _____

Address (if different from patient's)_____ City _____

State _____ Zip _____ Phone (____)_____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____)_____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan

_____

_____

Additional Insurance

Is patient covered by additional insurance? (circle one) Y N

Person Responsible for Account (Last, First, Middle Initial) _____

Relation to Patient _____ Birthdate _____ SSN # _____

Address (if different from patient's)_____ City _____

State _____ Zip _____ Phone (____)_____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____)_____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan

_____

_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with (Name of Insurance Company(ies)_____ and assign directly to (circle one) Dr. Allen Berman Dr. Michael Berman 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(ies) 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, Guardian or Personal Representative _____

Print Name _____ Relationship to Patient _____

Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved

Medical History

Physician's Name _____ Date of last visit _____

Indicate if you have or have had the following:

Anemia	Y	N	?	Hepatitis	Y	N	?
Arthritis, Rheumatism	Y	N	?	High Blood Pressure	Y	N	?
Artificial heart valves	Y	N	?	HIV/AIDS	Y	N	?
Artificial joints	Y	N	?	Jaw Pain	Y	N	?
Asthma	Y	N	?	Kidney Disease	Y	N	?
Back Problems	Y	N	?	Liver Disease	Y	N	?
Blood Disease	Y	N	?	Mitral Valve Prolapse	Y	N	?
Cancer	Y	N	?	Pacemaker	Y	N	?
Chemical Dependency	Y	N	?	Radiation Treatment	Y	N	?
Chemotherapy	Y	N	?	Respiratory Disease	Y	N	?
Circulatory Problems	Y	N	?	Rheumatic Fever	Y	N	?
Cortisone Treatment	Y	N	?	Scarlet Fever	Y	N	?
Cough, Persistent	Y	N	?	Shortness of Breath	Y	N	?
Coughing up Blood	Y	N	?	Skin Rash	Y	N	?
Diabetes	Y	N	?	Stroke	Y	N	?
Epilepsy	Y	N	?	Swelling of Feet/ Ankles	Y	N	?
Fainting	Y	N	?	Thyroid Problems	Y	N	?
Glaucoma	Y	N	?	Tobacco Habit	Y	N	?
Headaches	Y	N	?	Tonsillitis	Y	N	?
Heart Attack	Y	N	?	Tuberculosis	Y	N	?
Heart Murmur	Y	N	?	Ulcer	Y	N	?
Heart Problems	Y	N	?	Venereal Disease	Y	N	?
Hemophilia	Y	N	?	Vitamin Deficiency	Y	N	?

Medications

Please list any medications you are currently taking

_____

_____

_____

_____

_____

Allergies

Please list any foods, drugs or substances you are allergic to

_____

_____

Have you had any serious illnesses or operations? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Women only: Are you pregnant? Y N Nursing? Y N Taking birth control? Y N

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Indicate if you have had problems with the following:

Bad breath	Y	N	?	Grinding teeth/ Jaw pain	Y	N	?
Bleeding gums	Y	N	?	Loose teeth or broken fillings	Y	N	?
Clicking or popping jaw	Y	N	?	Periodontal treatment	Y	N	?
Food collection between teeth	Y	N	?	Sensitivity to cold	Y	N	?
Sores or growths in your mouth	Y	N	?	Sensitivity to hot	Y	N	?
Sensitivity to biting	Y	N	?	Sensitivity to sweets	Y	N	?

How often do you floss? (circle one) 2 times/day Once/day 3-4 times/week Seldom Never

How often do you brush? (circle one) 2 times/day Once/day 3-4 times/week Seldom Never

How do you feel about going to the dentist? Scared Apprehensive No Problem

Rate Your Smile

On a scale of 1-10, please circle which number indicates how satisfied you are with your smile. 1 is the lowest, 10 is the highest. This is purely subjective, but this may help us in achieving your perfect smile.

1 2 3 4 5 6 7 8 9 10