DR. STEPHEN BARAL, D.D.S.

PATIENT INFORMATION

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Address: _____
Street Apt. # City State Zip

Birthdate: ____/____/____ Telephone: Home: _____ Work: _____ Cellular/Pager: _____

Height: _____ Weight: _____ Sex: ☐ M ☐ F Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated

If Student, _____ ☐ Full Time ☐ Part Time
Name of School/College City State Grade

Patient's Employer: _____ Occupation: _____ SS#: _____

Business Address: _____
Street Suite # City State Zip

Spouse Name: _____ Employer: _____ Work Phone: _____

Person to contact in case of emergency: _____ Relationship: _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person? _____

Whom may we thank for referring you to our office? _____

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address (if different from above): _____
Street Apt. # City State Zip

Birthdate: ____/____/____ Telephone: Home: _____ Work: _____

SS #: _____ Driver's License #: _____

Primary Dental Coverage Information **If you do NOT have primary coverage, please check this box: ☐**

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ____/____/____

Address (if different from above): _____ City: _____ State: ____ Zip: _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

Secondary Dental Coverage Information **If you do NOT have secondary coverage, please check this box: ☐**

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ____/____/____

Address (if different from above): _____ City: _____ State: ____ Zip: _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

DENTAL HISTORY

Please answer each question by circling Yes or No.

Do you have a specific dental problem or chief complaint? Describe: _____ Yes No

Do you have dental examinations on a routine basis? When was your last visit? _____ Yes No

Do you think you have cavities or gum disease? _____ Yes No

Do you brush and floss on a routine basis? Describe: _____ Yes No

Do your gums ever bleed? Describe: _____ Yes No

Do you like your smile? Why? _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No

Have your past experiences in a dental office been positive? _____ Yes No

Name of previous dentist: _____ Date of last full mouth x-ray series: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____

(If patient is a minor, include printed name and signature of parent or legal guardian)

HEALTH HISTORY

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Please answer each question by checking the appropriate box or circling Yes or No.

1. Are you in good health? ..... Yes No
2. Date of last physical examination: _____
3. Are you now under the care of a physician? ..... Yes No
   If yes, what is the condition being treated? _____
   Doctor's name: _____ Telephone #: _____
4. Have you ever had any serious illness or operation or been hospitalized? ..... Yes No
   Please explain: _____
5. Are you taking any medication? ..... Yes No
   If yes, what? _____ What dosage? _____
6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? ..... Yes No
   If yes, what? _____
7. Have you ever been premedicated with antibiotics for your dental treatment? ..... Yes No
8. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Erythromycin
   ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other If Other, please list: _____ ..... Yes No
9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No — answer all conditions:

☐ Y ☐ N AIDS	☐ Y ☐ N Cortisone Medicine	☐ Y ☐ N Hemophilia	☐ Y ☐ N Respiratory Disease
☐ Y ☐ N Allergies or Hives	☐ Y ☐ N Diabetes	☐ Y ☐ N Hepatitis or Jaundice	☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Allergies to Metals	☐ Y ☐ N Difficulty in Swallowing	☐ Y ☐ N Herpes	☐ Y ☐ N Rheumatism
☐ Y ☐ N Anemia	☐ Y ☐ N Drug Addiction	☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Sickle Cell Disease
☐ Y ☐ N Angina Pectoris	☐ Y ☐ N Emphysema	☐ Y ☐ N HIV Positive	☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Arthritis	☐ Y ☐ N Epilepsy or Seizures	☐ Y ☐ N Joint Replacement	☐ Y ☐ N Stomach Ulcers
☐ Y ☐ N Artificial Heart Valve	☐ Y ☐ N Excessive Bleeding	☐ Y ☐ N Kidney Disease	☐ Y ☐ N Stroke
☐ Y ☐ N Asthma	☐ Y ☐ N Fainting Spells or Seizures	☐ Y ☐ N Liver Disease	☐ Y ☐ N TMJ
☐ Y ☐ N Blood Disease	☐ Y ☐ N Glaucoma	☐ Y ☐ N Mental Disorder	☐ Y ☐ N Thyroid Disease
☐ Y ☐ N Blood Transfusion	☐ Y ☐ N Hay Fever	☐ Y ☐ N Mitral Valve Prolapse	☐ Y ☐ N Tonsillitis
☐ Y ☐ N Bruise Easily	☐ Y ☐ N Head Injuries	☐ Y ☐ N Nervous Disorders	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Chemotherapy	☐ Y ☐ N Heart Ailments or Attack	☐ Y ☐ N Pain in Jaw Joints	☐ Y ☐ N Tumors or Growths
☐ Y ☐ N Cold Sores	☐ Y ☐ N Heart Failure	☐ Y ☐ N Psychiatric Treatment	☐ Y ☐ N Venereal Disease
☐ Y ☐ N Congenital Heart Lesions	☐ Y ☐ N Heart Murmur	☐ Y ☐ N Radiation Treatment	

10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: _____ ..... Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco? ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Snuff ☐ Other ..... Yes No
    If yes, how much? _____
12. Do you consume alcoholic beverages? If yes, how much? _____ ..... Yes No
13. Have you ever taken the drug "Fen-Phen" or "Redux"? ..... Yes No
14. Are you pregnant? If yes, how many months? _____ ..... N/A Yes No
15. Do you have any problems associated with your menstrual period? ..... N/A Yes No
16. Do you take birth control pills? ..... N/A Yes No
17. Is there anything we should know about your health that is not mentioned above? ..... Yes No
    Please explain: _____

1st I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____
(If patient is a minor, include printed name and signature of parent or legal guardian)

2nd *UPDATE – Since your last visit:*

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical condition or had surgery? ..... Yes No

If yes, please explain: _____

Date: _____ Signature: _____

3rd *UPDATE – Since your last visit:*

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical condition or had surgery? ..... Yes No

If yes, please explain: _____

Date: _____ Signature: _____

DO NOT WRITE IN THIS SPACE

	DATE	B.P.	PULSE	REVIEWED BY	DENTIST'S COMMENTS
1st	_____	___/___	_____	_____	_____
2nd	_____	___/___	_____	_____	_____