Steven M. Levy, D.M.D.

PLEASE FILL OUT THIS FORM

ALL INFORMATION IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT YOUR PERMISSION

____ SINGLE ___ MARRIED ___ SEPARATED ___ DIVORCED ___ WIDOWED ___

PATIENT'S NAME

____

IF A CHILD, PARENT'S NAME

RESIDENCE ADDRESS CITY STATE ZIP

HOME PHONE CELL PHONE EMAIL ADDRESS

EMPLOYED BY ADDRESS CITY STATE ZIP

PRESENT POSITION HOW LONG HELD?

SPOUSE - EMPLOYED BY ADDRESS CITY STATE ZIP

PATIENT'S SOCIAL SECURITY NUMBER WHO WILL PAY THIS ACCOUNT?

SPOUSE'S SOCIAL SECURITY NUMBER SPOUSE'S NAME

NAME OF YOUR DENTAL INSURANCE COMPANY AND POLICY NUMBER

WHO MAY WE THANK FOR REFERRING YOU OR HOW DID YOU FIND US?

DENTAL HISTORY

PREVIOUS DENTIST REASON FOR LEAVING DATE OF LAST VISIT

	YES	NO
HAVE YOU HAD A SERIOUS PROBLEM WITH YOUR PREVIOUS DENTAL TREATMENT?	___	___
DO YOU GENERALLY MAKE REGULAR VISITS TO THE DENTIST?	___	___
DO Y0UR GUMS BLEED OR FEEL TENDER OR SWOLLEN?	___	___
DO ANY TEETH FEEL LOOSE?	___	___
HAVE YOUR GUMS EVER BEEN TREATED?	___	___
DO YOU GRIND OR CLENCH YOUR TEETH?	___	___
DOES FOOD WEDGE BETWEEN YOUR TEETH?	___	___
ARE YOUR TEETH SENSITIVE TO HEAT, COLD, SWEETS OR BITING PRESSURE?	___	___
IF YOU HAVE ANY MISSING TEETH, ARE YOU INTERESTED IN HAVING THEM REPLACED?	___	___
DO YOU HAVE ANY PAIN IN OR AROUND YOUR EARS?	___	___
DOES YOUR JAW CLICK OR POP?	___	___
HAVE YOU HAD ANY PREVIOUS INJURY TO YOUR FACE OR JAWS?	___	___
DO YOU HAVE ANY FEAR OF HAVING DENTISTRY DONE?	___	___
DO YOU GAG EASILY?	___	___
DO YOU FEEL YOUR TEETH COULD BE WHITER?	___	___

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH? ____

PLEASE SHARE WITH US ANYTHING YOU FEEL IS IMPORTANT. ____

MEDICAL HISTORY

BIRTH DATE ____ AGE ____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? **INDICATE A 'YES' WITH A CHECK MARK ( )**

___ ANGINA (CHEST PAINS)
___ ARTIFICIAL HEART VALVES
___ CIRCULATORY PROBLEMS
___ CORONARY BY-PASS/STENTS
___ HEART AILMENT OR OPERATIONS
___ HEART ATTACK
___ HEART MURMUR
___ HIGH BLOOD PRESSURE
___ LOW BLOOD PRESSURE
___ PACE MAKER
___ STROKE
___ ANEMIA
___ ARTHRITIS
___ ARTIFICIAL JOINT REPLACEMEMNTS
___ ASTHMA
___ BLOOD DISEASE
___ CANCER OR MALIGNANCY
___ DIABETES
___ EATING DISORDER/ANOREXIA/BOLEMIA
___EMPHYSEMA
___ EPILEPSY, SEIZURES OR CONVULSIONS
___FAINTING SPELLS/DIZZINESS
___ GLAUCOMA
___ HAY FEVER
___ HEPATITIS
___ HERPES
___ HIGH CHOLESTEROL
___ HIV/AIDS
___ KIDNEY DISEASE
___ LYME DISEASE
___ LIVER DISEASE
___ LUPUS
___ MULTIPLE SCLEROSIS
___ NERVOUS DISORDERS
___ PARKINSON'S DISEASE
___ PROLONGED BLEEDING
___ PSYCHIATRIC CARE
___ RADIATION OR CHEMOTHERAPY
___RESPIRATORY DISEASE/COPD
___ RHEUMATIC FEVER
___ RHEUMATISM
___ SCARLET FEVER
___ SINUS PROBLEMS
___ STOMACH/INTESTINAL DISEASE/ACID REFLUX
___ THYROID PROBLEMS
___ TUBERCULOSIS
___ TUMOR OR GROWTHS
___TYPHOID FEVER
___ ULCERS
___ VENEREAL DISEASE
___ OTHER

ARE YOU ALLERGIC TO: DO YOU PRE-MEDICATE BEFORE DENTAL TREATMENT? ___ YES ___ NO

___ PENICILLIN/AMOXICILLIN? ___ LOCAL ANESTHETICS? ___ MINOCYCLINE?/TETRACYCLINE? ___LATEX?

OTHER DRUGS ____

DO YOU SMOKE? ____________________

ARE YOU PREGNANT? _______________ MOS. ________ ARE YOU TAKING BIRTH CONTROL PILLS? _____________

PHYSICIANS NAME, ADDRESS, PHONE NUMBER ____

DATE OF LAST COMPLETER PHYSICAL EXAM ____

GENERAL HEALTH: ___ EXCELLENT ___ GOOD ___ FAIR ___ POOR

ARE YOU PRESENTLY UNDER PHYSICIANS TREATMENT? ___________ FOR WHAT? ______________________________

PLEASE LIST ANY MAJOR OPERATIONS OR HOSPITALIZATIONS ____

____

PLEASE LIST ANY MEDICATIONS OR SUPPLEMENTS YOU ARE TAKING AND FOR WHAT PURPOSE. ____________________

____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING OPERATIONS, OR ANY OTHER MEDICAL OR DENTAL INFORMATION THAT MAY POSSIBLY AFFECT YOUR HEALTH OR DENTAL TREATMENT. ____________________________

____

SIGNATURE ____ DATE ____________________