

WELCOME TO OUR OFFICE

Paul Arfanis DDS * 228 Saint Paul Street * Westfield, New Jersey 07090

Telephone no. (908) 232-0074 * Facsimile no. (908) 232-0101

Your Name:

Date:

What do you prefer to be called?

DOB:

Marital Status S M D W

Home Address:

City:

State:

ZIP Code:

Telephone:

Social Security Number:

Occupation:

Telephone no.

Employer:

Length of Employment:

Employer's Address:

City:

State:

ZIP Code:

Who should we thank for your referral:

PRIMARY CARE PHYSICIAN:

Address:

Telephone no.

NAME OF SPOUSE:

Occupation:

Social Security Number:

Employer:

Telephone no.

IN THE CASE OF AN EMERGENCY:

Contact:

Relationship:

Telephone no.

COMPLETE THIS SECTION IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE. (*)

Responsible Party:

Relationship:

(*) The patient and responsible party listed above hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles, which arise during the course of treatment for the patient. The patient and/or responsible party also agrees to pay for treatment rendered to patient, which is not considered to be a covered service by third party insurers or payors. If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% per month will be assessed on the unpaid balance. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Note: (Waiver Clause) It is customary for our office to take photographs of our patients. Before and after pictures of dental work are kept for your records. Some of them may be utilized for publications, patient demonstration, and/or web site. Your confidence will be strictly observed.

Please tell us if you would allow our office to utilize your photographs for publication.

YES, I do authorize Dr. Arfanis to publish my photographs

NO, I do not wish to publish my photographs.

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office - to the best of your ability honest answers must be given. If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor. Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided, but all questions must be answered. To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is a "Permission to Release Information". You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND ANY RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESSED AND WRITTEN PERMISSION.

PLEASE USE THE SPACE BELOW TO TELL US ANYTHING WE CAN DO TO HELP MAKE YOUR VISIT WITH US MORE COMFORTABLE:

1. a.) Name address & telephone # of your physician: _____

b.) Do you see any medical specialists? _____

2. Date of last visit to your doctor _____ Purpose of visit _____

3. Do you suffer from any disability? _____ If yes, describe _____

4. Do you take any drugs or medications? _____ if yes, list and describe amounts and purpose. _____

5. Have you ever had allergic reaction to medication? _____ If yes describe _____

6. Have you lost weight recently? _____ If yes, please tell us the reason and how much weight you lost _____

Have You Ever Had, Or Been Treated For:

7. Have you ever had or been treated for a heart infection? _____

8. Have you ever had heart surgery, had a heart valve replaced or repaired? _____ if yes, please explain? _____

9. Have you ever or do you now take illegal drugs? _____ If yes, what drugs, and when taken _____

Note: *There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.*

10. Do you have AIDS, or are you HIV - positive? _____ If yes, describe and provide current status. _____

11. Do you now have, or have you ever had a venereal disease? _____ If yes, describe. _____

12. Have you ever had, or do you now have hepatitis? _____ If yes, describe _____

13. **For our female patients:** Are you pregnant? _____ If yes, when are you due? _____

14. Are you taking birth control pills? _____

NOTE: *There are drugs and medications used in routine dental care that may reduce the effectiveness of contraceptives.*

15. Stomach or intestinal disease? _____

16. Abnormal blood pressure, excessive bleeding, or anemia? _____

17. Breathing problems: asthma, tuberculosis, or hay fever? _____

18. Cancer, X-ray treatments, or chemotherapy? _____
19. Diabetes or Hypoglycemia? _____ Does it occur in your immediate family? _____
20. Kidney problems or Renal Dialysis? _____
21. A stroke, convulsion, or fainting spells? _____
22. Tumors or growths? _____
23. a.) Arthritis or rheumatism? _____
- b.) Do you have any limitation to your ability to sit in a dental chair? _____
24. Have you ever had a major operation? If yes, describe _____
25. Have you ever had a serious injury to your head or neck? _____ If yes, describe _____
26. Are you on a special diet? _____ If yes, for what reason and describe _____
27. Do you smoke? _____ If yes, describe type and quantity. _____
28. Are there any other problems about your health of which you are aware? _____

DENTAL HISTORY

Date of your last visit to a dentist _____ Reason for your last visit /or series of visits: _____

With respect to any previous dental treatment have you:

29. Ever fainted? _____
30. Had abnormal bleeding? _____
31. Any other complications during or following dental treatment? _____ If yes, describe _____
32. Do your gums bleed on brushing or eating? _____
33. Does food catch between your teeth? _____
- | | | |
|---|-----|----|
| 34. Have your teeth shifted | YES | NO |
| Are there spaces between your teeth now where there were none | YES | NO |
| Are your teeth-flaring | YES | NO |
| Are some of your teeth becoming loose? | YES | NO |
35. Are any of your teeth sensitive to heat, cold, pressure or Chewing? _____
36. Do you have pain or clicking in the jaw joint next to ear? _____
37. Have your jaw muscles ever been sore? _____ If yes, describe _____
38. Are there any sores or growths in your mouth? _____
39. Do any of your teeth ache ? _____

40. Do you have any other dental complaint? _____

NOTE: A CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THE OFFICE AT THE EARLIEST POSSIBLE TIME.

To the best of my knowledge, the foregoing questions have been accurately answered.

Signature: _____ **Date:** _____

Print Name: _____ **Date:** _____

If other than patient, indicate relationship _____

PERMISSION TO RELEASE HEALTH INFORMATION:

I grant the right to the dentist to release health information obtained from me, information about my dental treatment to third party payors, and/or other health practitioners.

Person completing the form:

Signature: _____ **Date:** _____

Print Name: _____ **Date:** _____

If other than patient, indicate relationship _____

Dentist's History Review & Significant Findings

Signature Dr. Arfanis _____ Date ____/____/____