WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

PAUL E. APPELBAUM, D.M.D., 1445 WAMPANOAG TRAIL, RIVERSIDE, RI. 02915 (401) 433-2400

About You

Today's Date: ______________ Email: ______________________________

Name: ________________________________ I prefer to be called: ______________ ❑ Male ❑ Female
Last First MI Mr Mrs Ms Dr

Birthdate: ___/___/___ Height: ____ Weight: ____ Social Security #: ______________ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: ____
Street City State Zip

Home Phone #: (____)________ Work Phone #: (____)________ Ext: ____ Cell #: (____)________ Driver's License #: __________

Where & when are best times to reach you? ______________ Whom may we thank for referring you? ______________

Names and ages of children: ____

Other family members seen by us: ____

Employer: ______________________ How long there? __________ Occupation: ______________

Employer's Address: ____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: ______________ Relation: __________ Work Phone #: (____)________ Home Phone #: (____)________

Address: ____
Street City State Zip

Spouse Information

His / Her Name: ______________________ Birthdate: ___/___/___ Social Security #: ______________

Employer: ______________ How long there? ______ Work Phone #: (____)________ Ext: _____

Occupation: __________ Address: ____
Street City State Zip

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______________ Phone #: (____)________ Group # (Plan, Local or Policy #): ______________

Insurance Co. Address: ____
Street/PO Box City State Zip

Insured's Name: ______________ Insured's Social Security #: ______________ Insured's Birthdate: ___/___/___ Relation: __________

Insured's Employer: ______________ Employer's Address: ____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______________ Phone #: (____)________ Group # (Plan, Local or Policy #): ______________

Insurance Co. Address: ____
Street/PO Box City State Zip

Insured's Name: ______________ Insured's Social Security #: ______________ Insured's Birthdate: ___/___/___ Relation: __________

Insured's Employer: ______________ Employer's Address: ____
Street/PO Box City State Zip

Dental History

Why have you come to the dentist today? ______

Are you currently in pain? ❑ Yes ❑ No
Do you have pain in your Jaw Joints? ❑ Yes ❑ No
Do you require antibiotics before dental treatment? ❑ Yes ❑ No
Your current dental health is ❑ Good ❑ Fair ❑ Poor
Do you floss daily? ❑ Yes ❑ No
Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft
Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No
Have you ever had periodontal disease? ❑ Yes ❑ No
Are your teeth sensitive to heat, cold, or anything else? ______

Do you have mobility in your teeth? ❑ Yes ❑ No
Do you still have wisdom teeth? ❑ Yes ❑ No
Previous Dentist: ______
Date of last visit: ______ Date of last Cleaning: ______
Address: ______
Street
______
City State Zip
Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No
Are you happy with the way your smile looks? ❑ Yes ❑ No
If not, what would you change? ______

Medical History

Do you have a personal physician? ❑ Yes ❑ No
Physician's Name: ______
Address: ______
Street
______
City State Zip
Phone #: (___) ______ Date of last visit: ______
Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No
Please explain: ______
Do you smoke or use tobacco in any other form? ❑ Yes ❑ No
If yes, How much? ______
Have you ever taken Fosamax or any other bisphosphonate? ❑ Yes ❑ No
For Women: Are you taking birth control pills? ❑ Yes ❑ No
Are you pregnant? ❑ Unsure ❑ Yes ❑ No
Week #: ______ Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Ever Hospitalized
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma
Y N Hay Fever
Y N Headaches
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tonsillitis
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: ______
Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list each one: ______

Are you allergic to any of the following?

Y N Aspirin
Y N Barbiturates
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry / Metals
Y N Latex
Y N Penicillin
Y N Sedatives
Y N Sulfa Drugs
Y N Tetracycline
Y N Other

Please list anything additional that causes allergic reactions: ______

Authorization

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any changes in my health status or medication(s). The undersigned hereby authorizes Doctor to take radiographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs.

______ Patient Signature Date

______ Parent or Responsible Party Date Relationship to Patient: ______

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