

**Bernard D. Gorkowitz, D.D.S.
Orthodontist**

***Our office is committed to meeting or exceeding the standards of infection control
Mandated by OSHA, the CDC and the ADA***

PATIENT INFORMATION

NAME: _____ TODAY'S DATE: ____/____/____
LAST FIRST MI
DATE OF BIRTH: ____/____/____
() SINGLE () MARRIED () DIVORCED () SEPARATED () WIDOWED

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE NUMBER: () _____ - _____ CELL NUMBER: () _____ - _____

WORK PHONE NUMBER: () _____ - _____ E-MAIL: _____

YOUR S.S. #: _____ - _____ - _____ RESPONSIBLE PARTY: _____

YOUR EMPLOYER: _____ YOUR OCCUPATION: _____

EMPLOYER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WHO MAY WE THANK FOR REFERRING YOU: _____

DENTAL INSURANCE

INSURED PARTY: _____ INSURED'S DATE OF BIRTH: _____

INSURED'S EMPLOYER: _____ S.S. #: _____ - _____ - _____

DENTAL INSURANCE PLAN: _____ GROUP NUMBER: _____

DO YOU HAVE SECONDARY INSURANCE? YES _____ NO _____

DENTAL INSURANCE PLAN: _____ GROUP NUMBER: _____

INSURED PARTY: _____ INSURED'S DATE OF BIRTH: _____

INSURED'S EMPLOYER: _____ S.S. #: _____ - _____ - _____

We will prepare necessary forms or reports to help you obtain your benefits from the insurance companies. You are responsible to know the details of your insurance coverage since the contract is between you and your insurance company. PLEASE BE ADVISED THAT THE FINANCIAL RESPONSIBILITY FOR YOUR TREATMENT ULTIMATELY RESTS WITH YOU, NOT YOUR INSURANCE COMPANY.

SIGNATURE: _____ DATE: ____/____/____

MEDICAL HISTORY

Your current physical health is: ___ Good ___ Fair ___ Poor

Are you currently under the care of a physician? ___ No ___ Yes Last Medical Exam: ____/____/____

Please explain _____

Are you taking any prescription / over-the-counter drugs? ___ No ___ Yes

Please list each one: _____

Have you taken any recreational drugs during the past 3 months? ___ No ___ Yes

If yes, please list: _____

Have you had any of the following diseases or medical problems?

- | | | | | | |
|---|---|-----------------------------|---|---|---------------------------------------|
| Y | N | Heart Attack / Stroke | Y | N | Psychiatric Problems |
| Y | N | Heart Murmur | Y | N | Epilepsy / Seizures / Fainting Spells |
| Y | N | Mitral Valve Prolapse | Y | N | Diabetes / Tuberculosis (TB) |
| Y | N | Rheumatic Fever | Y | N | Drug / Alcohol Abuse |
| Y | N | Heart Surgery / Pacemaker | Y | N | Venereal Disease |
| Y | N | Artificial Valves | Y | N | Hemophilia / Abnormal Bleeding |
| Y | N | Congenital Heart Defect | Y | N | Ulcers / Colitis |
| Y | N | High / Low Blood Pressure | Y | N | Cancer / Chemotherapy |
| Y | N | Kidney Problems | Y | N | Anemia / Radiation Treatment |
| Y | N | Artificial Bones / Joints | Y | N | Arthritis |
| Y | N | Asthma | Y | N | Glaucoma |
| Y | N | Difficulty Breathing | Y | N | HIV+ / AIDS |
| Y | N | Emphysema | Y | N | Hepatitis |
| Y | N | Sinus Problems | Y | N | Blood Transfusion |
| Y | N | Severe / Frequent Headaches | Y | N | Hospitalized for any reason |

Are you allergic to any of the following items?

- | | | | | | |
|---|---|--------------|---|---|----------------------|
| Y | N | Penicillin | Y | N | Tetracycline |
| Y | N | Aspirin | Y | N | Dental Anesthetics |
| Y | N | Erythromycin | Y | N | Any Metal / Plastics |
| Y | N | Latex | Y | N | Codeine |

Please list any other drugs that you are allergic to: _____

For Women:

- | | | | | | |
|---|---|--------------------------|---|---|-------------------|
| Y | N | Currently Pregnant | Y | N | Currently Nursing |
| | | Due Date: ____/____/____ | Y | N | Menopause |

DENTAL HISTORY

What is your chief complaint? _____

General Dentist: _____ Last Dental Visit: _____

Please indicate if any of the following pertain to you:

- | | | | | | |
|---|---|--|---|---|--|
| Y | N | Pain in or near your ears | Y | N | Sensitive Teeth |
| Y | N | Any unhealed injuries or inflamed areas
in or around your mouth | Y | N | Food Impaction |
| Y | N | Any growth spots in your mouth | Y | N | Burning tongue |
| Y | N | Discomfort in any part of your mouth | Y | N | Unpleasant taste |
| Y | N | Have you ever had any reaction to a
a dental injection | Y | N | Unfavorable dental experience |
| Y | N | Any difficult extractions in the past | Y | N | Bad Breath |
| Y | N | Prolonged bleeding following extractions | Y | N | Mouth breathing |
| Y | N | Trench Mouth | Y | N | Oral Habits – fingernail biting,
cheek biting, etc. |
| Y | N | Bleeding gums | Y | N | Do you use cigarettes, pipes or
cigars |
| Y | N | Do you use dental floss | Y | N | Do you clench your teeth |
| Y | N | Have you received instructions on the correct method of brushing your teeth. | | | |

Texture of tooth brush _____ Frequency of brushing _____ time(s) per day

Y N Do you only chew on one side of your mouth? If yes, why? _____

Y N Do you wear denture, partial or full?
If so, how long have you worn dentures? _____

Y N Are you happy with your smile and/or color of your teeth?
If no, explain _____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

So that we maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees. Once you have made an appointment, remember this time is reserved for you. Therefore, if you must cancel an appointment, please give us sufficient notice.

Signature: _____ Date: _____

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(FOR OFFICE USE)

I verbally reviewed the medical and dental information above with the patient named herein.

This patient _____ does / _____ does not require premedication prior to dental treatment.

Medication for Pre Med _____ Doctor's Initials _____ Date _____