Serenitydental

JAY M. BHATT DDS

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Preferred Name _____

Check Appropriate Box:

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Other _____

Birth Date _____ Social Security # _____ Drivers License # _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Referred By _____ Has any other family member been seen in our office? _____

RESPONSIBLE PARTY - *Check if same as above* ☐

Last Name _____ First Name _____ M.I. _____ Preferred Name _____

Check Appropriate Box:

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Other _____

Birth Date _____ Social Security # _____ Drivers License # _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

INSURANCE INFORMATION

Policy Holder _____ Birth Date _____ Social Security # or ID # _____

Employer _____ Insurance Co _____ Group# _____

Do you have additional dental insurance? ☐ Yes ☐ No If yes, then complete the following:

Policy Holder _____ Birth Date _____ Social Security # or ID # _____

Employer _____ Insurance Co _____ Group# _____

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Patient Name: _____ Birth Date: _____

HEALTH HISTORY

	YES	NO
Has there been a change in your health within the last year?	☐	☐
Have you been hospitalized or had a serious illness in the last two years?	☐	☐
If yes, explain? _____		
Are you being treated by a physician now?	☐	☐
If yes, explain? _____		
Physicians name _____ Phone _____		
Date of last medical exam? _____		
Do you smoke or use tobacco products? If yes, how many packs per day?	☐	☐
Are you taking Bisphosphonates (Fosomax, Actonel, Boniva Aredia, Bonefos, Didronel, Zometa)?	☐	☐
Are you now taking any medication (including asprin) or herbal supplements?	☐	☐
If yes, please list _____		
_____		
Are you sensitive or allergic to any medication or anesthetics?	☐	☐
If yes, please list _____		

Do you have any specific dental concerns today?

_____

_____

_____

Do you or have you had:

Yes	No		Yes	No		Yes	No	
☐	☐	Adrenal Disease	☐	☐	Diabetes	☐	☐	Jaundice
☐	☐	A.I.D.S	☐	☐	Drug Addiction	☐	☐	Latex Allergy
☐	☐	Allergies	☐	☐	Emphysema	☐	☐	Liver Disease
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Mental Disorders
☐	☐	Angina Pectorus	☐	☐	Eye Disease	☐	☐	Mitral Valve Prolapse
☐	☐	Arteriosclerosis	☐	☐	Glaucoma	☐	☐	Osteoporosis
☐	☐	Arthritis	☐	☐	Heart Attack	☐	☐	Radiation Treatment
☐	☐	Artificial Heart Valve	☐	☐	Heart Disease	☐	☐	Rheumatic Fever
☐	☐	Artificial Joints	☐	☐	Heart Murmur	☐	☐	Rheumatism
☐	☐	Asthma	☐	☐	Heart Pacemaker	☐	☐	Stroke
☐	☐	Bleeding Disorders	☐	☐	Heart Surgery	☐	☐	Sub-Bacterial Endocarditis
☐	☐	Blood Transfusion	☐	☐	Hemophilia	☐	☐	Thyroid Problems
☐	☐	Cancer	☐	☐	Hepatitis A	☐	☐	Transplant
☐	☐	Chemotherapy	☐	☐	Hepatitis B	☐	☐	Tuberculosis
☐	☐	Chronic Cough	☐	☐	Hepatitis C	☐	☐	Tumors
☐	☐	Colitis	☐	☐	H.I.V. Positive	☐	☐	Ulcers
☐	☐	Congenital Heart Disease	☐	☐	High Blood Pressure	☐	☐	Venereal Disease

Do you experience:

☐	☐	Chest Pain	☐	☐	Dizziness	☐	☐	Sinus problems
☐	☐	Swollen Ankles	☐	☐	Ringing in Ears	☐	☐	Excessive bleeding
☐	☐	Shortness of Breath	☐	☐	Blurred Vision	☐	☐	Difficulty Swallowing
☐	☐	Recent Weight Loss	☐	☐	Frequent Urination	☐	☐	Dry Mouth
☐	☐	Bruise Easily	☐	☐	Nausea / Frequent Vomiting	☐	☐	

Do you have or have you had any other diseases, conditions, or medical problems NOT listed on this form? ☐ Yes ☐ No

If yes, please explain: _____

WOMEN ONLY:

	Yes	No		Yes	No		Yes	No
Are you or could you be pregnant?	☐	☐	Taking birth control pills?	☐	☐	Are you nursing?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. I unders tand that providing incorrect information can be dangerous to my health. I will inform you of any changes in my health or medication

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____