

Igor Ochev, D.D.S.
Aesthetic and Family Dentistry

General Information Sheet

Welcome to our practice. So that we may provide you with the best possible care, please complete this form.
All information is completely confidential.

Date _____
Patient Name _____
Address _____
City _____ State _____ Zip _____
Home Phone () _____
Fax () _____
Cell phone () _____
Is another member of your family or relative a patient
at our office? _____

Prefers to be called _____
Age _____ Gender: M F
Date of Birth _____
Single__ Married__ Domestic Partner__ Divorced__ Minor__ Separated__
SSN _____ - _____ - _____
Drivers License Number _____
E-Mail _____ @ _____
Full time student? Yes No
School Name _____

Billing Address, if different:

Whom may we thank for referring you?

Employed by _____
Business Address _____
Business Phone () _____
E-Mail _____
Present position _____

Spouse/Partner _____
Employed by _____
Business Address _____
Business Phone () _____
Present Position _____

Person responsible for account _____

Dental Insurance

PRIMARY CARRIER

Insurance Company _____
Address _____
City _____ State _____ Zip _____
Tel _____ Group No _____
Employer Name _____
Insured's Name _____
Insured's Date of Birth _____
Relationship to Patient _____
Insured's I.D. No _____
Insured's SSN _____
Closest Relative not living with you

Phone Number _____
Address _____
City _____ State _____ Zip _____

SECONDARY CARRIER

Insurance Company _____
Address _____
City _____ State _____ Zip _____
Tel _____ Group No _____
Employer Name _____
Insured's Name _____
Insured's Date of Birth _____
Relationship to Patient _____
Insured's ID No _____
Insured's SSN _____
Person to contact for emergency

Phone Number _____
Address _____
City _____ State _____ Zip _____

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Medical Information Sheet

All information is completely confidential.

Patient Name _____

1 Name of Medical Doctor _____ Phone () _____

2 Last appointment with M.D. _____ Reason _____

3 Address _____ City _____ State _____ Zip _____

4 Are you taking any over the counter, prescription or herbal medication, drugs or pills now? Yes No

Medicine	Dosage	Reason	Medicine	Dosage	Reason
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

5 Have you ever had an allergic or adverse reaction to:

- | | | | | | |
|-----------------|-----|----|----------------------|-----|----|
| a. Aspirin | Yes | No | e. Shell Fish/Iodine | Yes | No |
| b. Penicillin | Yes | No | f. Codeine | Yes | No |
| c. Erythromycin | Yes | No | g. Dental Anesthetic | Yes | No |
| d. Sulfa Drugs | Yes | No | h. Other _____ | | |

6 Have you ever had surgery or been hospitalized? Yes No

7 Have you ever pre-medicated for dental appointments? Yes No

8 Have you lost or gained more than ten pounds in the last year? Yes No

Indicate which of the following have you had or currently have. *Circle "yes" or "no" for each item.*

Heart Trouble

Rheumatic fever	Yes	No
Rheumatic heart disease	Yes	No
Heart murmur	Yes	No
Congenital heart disease	Yes	No
Mitral valve prolapsed	Yes	No

Heart Disease

Heart attack; Yr.: _____	Yes	No
Angina pectoris or chest pain	Yes	No
Heart surgery; Yr. _____	Yes	No
High blood pressure	Yes	No
Prosthetic or Implant Surgery		
Hip joints	Yes	No
Pacemaker	Yes	No
Heart valve	Yes	No
Cosmetic (e.g. facial or breast augmentation)	Yes	No

Tumor or Cancer

Chemotherapy	Yes	No
Radiation treatment	Yes	No
Diabetes	Yes	No

Blood disorder

Anemia	Yes	No
Sickle cell disease	Yes	No
Easy bruising	Yes	No
Hemophilia	Yes	No
Blood clotting disorders	Yes	No
Excessive or prolonged bleeding	Yes	No

Breathing Disorders

<i>Lung disease</i>		
Tuberculosis	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
Bronchitis	Yes	No
Hay fever	Yes	No
Sinus trouble	Yes	No
Shortness of breath	Yes	No

Kidney Disease

Urinary or bladder disorders	Yes	No
Renal dialysis	Yes	No

Liver Disease

Hepatitis Yes No
Cirrhosis Yes No
HIV, AIDS, ARC Yes No
Blood Transfusions Yes No

Gastrointestinal Disorders

Stomach or intestinal disease Yes No
Ulcers Yes No

Glaucoma

Yes No

Neurological Disorders

Stroke; Yr. ____ Yes No
Epilepsy; Last seizure: _____ Yes No
Fainting or dizzy spells Yes No
Headaches Yes No
Serious head or neck injury Yes No

Thyroid disorders

Yes No

Arthritis or Rheumatism

Yes No

Venereal Disease

Yes No

Metal Allergies

Yes No

Are you on a special or restricted diet? Yes No
Have you consulted or been treated by a psychiatrist? Yes No
Have you ever smoked? Yes No PPD _____ How many years? _____
Are you using any other tobacco products? _____ Yes No

Women

Are you **Pregnant?** Yes No **Nursing?** Yes No **Taking Birth Control Pills?** Yes No
Are you in or passed through menopause? Yes No

Do you have any disease, condition, or problem not listed? Yes No

I understand that the above information is necessary to provide me with dental care in a safe and 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 change in my health or medication.

Signature _____

Date _____

If other than patient, indicate relationship _____

Reviewed by _____