

Nelly Silva, DMD

WE WELCOME NEW PATIENTS

(Ask about our Whitening Program / Care to Share program)



Patient Name: _____ Date of Birth: _____ Male
 Last First Middle Initial Female

Address: _____
 (mailing) Street City State Zip code

Address: _____
 (residence) Street City State Zip code Single Married

E-mail Address: _____

Telephone (home): _____ Social Security #: _____

Telephone (work): _____ Employer: _____ Cell or Pager: _____

If Child, Parent's or Guardian's Name: _____

Name of Spouse: _____

Birth date: _____ Employer: _____

Person Responsible for this account: _____

In case of emergency, Who should we notify?: _____ Telephone: _____

How were you referred to our office? _____

Do you have Dental Insurance? yes no

Name of Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Social Security #: _____ Birthdate: _____

Group of Policy #: _____ Membership #: _____ Dental Plan #: _____

Is there Secondary Dental Insurance? yes no

Name of Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Social Security #: _____ Birthdate: _____

Group of Policy #: _____ Membership #: _____ Dental Plan #: _____

Health History: Name of Physician: _____ Telephone: _____

Are Taking Any Medications? yes no If Yes, What? _____

Do You Have Any Allergies (or adverse reaction) to Any medications? no yes _____

Penicillin Sulfa Drugs Aspirin Epinephrine

Please Circle Any Of The Following That Apply:

- | | | | | |
|---------------------|----------------------|--------------|-------------------|-----------------------|
| Heart Problem | AIDS/HIV | Lung Disease | Artificial Joints | Thyroid Disease |
| Rheumatic Fever | Drug addiction | Emphysema | Abnormal Bleeding | Mitral Valve Prolapse |
| High Blood Pressure | Cancer | Asthma | Ulcers | Pregnant |
| Arthritis | Hepatitis A, B, or C | Diabetes | Fainting | Other: _____ |
| Heart Murmur | Pacemaker | Tuberculosis | Epilepsy | None Apply |

Chemotherapy
 Have you been taking Fosamax, Actonel, Zometa, Aredia or Pamidronate? yes no

Dental History: How long since your last dental appointment? _____ How often do you have dental examinations? _____

Previous dental x-rays were taken: less than a year longer than a year

Have You Had Any Of The Following? (Please check if yes)

Have you experienced any of the following problem in your jaw?

- | | | | |
|---|------------------------------|---|------------------------------|
| Do you experience pain (joint, ear, side of face) | <input type="checkbox"/> yes | Do you wear a dental night guard? | <input type="checkbox"/> yes |
| Do you have dizziness | <input type="checkbox"/> yes | Have you ever had periodontal (gum) treatment? | <input type="checkbox"/> yes |
| Ringing in the ear | <input type="checkbox"/> yes | Have you ever had your bite adjusted? | <input type="checkbox"/> yes |
| Ear congestion | <input type="checkbox"/> yes | Do you bite your lips or cheeks often? | <input type="checkbox"/> yes |
| Do you have difficulty in opening or closing? | <input type="checkbox"/> yes | Do you smoke? | <input type="checkbox"/> yes |
| Do you have difficulty chewing? | <input type="checkbox"/> yes | Do you think you have occasional bad breath? | <input type="checkbox"/> yes |
| Do you have frequent headaches? | <input type="checkbox"/> yes | Do your gums ever bleed when you clean your teeth? | <input type="checkbox"/> yes |
| Have you had any head, neck, or jaw injuries? | <input type="checkbox"/> yes | Do you snore or have been told that you do? | <input type="checkbox"/> yes |
| Does your jaw 'click' or hurt? | <input type="checkbox"/> yes | Do you have daytime drowsiness? | <input type="checkbox"/> yes |
| Do you feel you grind or clench your teeth while awake or asleep? | <input type="checkbox"/> yes | Have you been told that you stop breathing when sleeping? | <input type="checkbox"/> yes |
| Have you ever had orthodontic treatment? | <input type="checkbox"/> yes | Do you feel un-refreshed in the morning? | <input type="checkbox"/> yes |
| | | Do you have morning hoarseness? | <input type="checkbox"/> yes |

other notes: _____

