General Dentistry
Jeffrey Berkowitz, DDS
Gregory C. Chan, DDS
Bryan Connolly, DDS
Steven R. Fischer, DDS
Christopher J. Lupariello, DMD
Brad Turner, DMD

Periodontics & Dental Implants
Francois D. Letourneau, DMD

Date______________________

PATIENT INFORMATION

Full Name____ Soc. Sec. #____________________ Date of Birth___________________

Address____ City____ State/ZIP______________

E-mail address ____________________________________

My Physician's Name____ ☐ Male ☐ Female Home Phone____________

Employer____ Work Phone ________________ Cell Phone _____________

How would you like to be addressed? Mr. Mrs. Ms. Dr. First Name or _______________________ Where should we confirm your appointment? ☐ Home ☐ Cell

Who should we contact in case of emergency? Name____

Relationship to patient____ Emergency contact phone #________________________

Are you allergic to any medications or substances? Please check box below.
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other_______________________________

WOMEN: (Please check) ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss__________________

Do you now have or have you ever had any of the following? Please check appropriate boxes.

***If yes to any of the starred conditions, please call prior to your appointment. Pre-medication may be required.**

☐ Artificial Joint*	☐ Angina/Chest Pain	☐ Leukemia	☐ AIDS
☐ Heart Murmur* (Presently)	☐ Excessive Bleeding	☐ Cancer	☐ HIV Positive
☐ Artificial Heart Valve*	☐ Sickle Cell Disease	☐ X-ray Treatments (Radiation)	☐ Cortisone Medicine
☐ Heart Pace Maker*	☐ Hemophilia (Bleeding Problem)	☐ Chemotherapy	☐ Substance Abuse
☐ Heart Surgery*	☐ Anemia	☐ Stomach/Intestinal Disease	☐ Stroke
☐ Mitral Valve Prolapse*	☐ Recent Blood Transfusion	☐ Ulcers	☐ Epilepsy or Seizures
☐ Rheumatic Fever*	☐ Blood Disease	☐ Recent Weight Loss	☐ Fainting or Dizziness
☐ Diabetes	☐ Hypoglycemia	☐ Frequent Diarrhea	☐ Glaucoma
☐ Hepatitis A (Infectious)	☐ Shortness of Breath	☐ Liver Disease	☐ Psychiatric Care
☐ Hepatitis B or C	☐ Sinus Trouble	☐ Renal Problems	☐ Alzheimer's Disease
☐ Irregular Heart Beat	☐ Asthma	☐ Renal Dialysis	☐ Allergies (Medicine)
☐ Heart Attack/Failure	☐ Emphysema	☐ Thyroid Disease	☐ Scarlet Fever
☐ High Blood Pressure	☐ Tuberculosis	☐ Parathyroid Disease	☐
☐ Low Blood Pressure	☐ Lung Disease	☐ Arthritis/Gout	☐
☐ Congenital Heart Disorder	☐ Breathing Problem	☐ Rheumatism	☐

Have you taken or are you taking medication known as **Bisphosphonate**: injectable form- Zometa, Aredia, Bonefos, Boniva; oral form- Fosamax, Didronel, Actonel, Skelid, Boniva, Ostac? ☐ Yes ☐ No

Are you taking any other medications? ☐ Yes ☐ No

Medications Taken:	Reason Taken:	Date started/will start taking this medication?
________________________________	________________________	__________________________
________________________________	________________________	__________________________
________________________________	________________________	__________________________

Have you ever had any other serious illness not checked above? Discuss______________________________________ ☐ Yes ☐ No

Do you wish to talk to the dentist privately about any problem?____ ☐ Yes ☐ No

X____Date______________________

Patient Signature (Parent or Guardian)

Reviewed by Doctor____Date________________________

History Review and Significant Findings:____

____

PLEASE COMPLETE OTHER SIDE

DENTAL INFORMATION

What prompted you to seek dental care at this time?____

Do you have any dental or jaw discomfort or pain at this time?____

When was your last dental checkup?______________________ Dental "Cleaning"?______________________

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

Discuss:____

Have you been seeing a dentist regularly for checkups and care? ☐ Yes ☐ No

If so, how often?____

Are you satisfied with your past dental experiences? ☐ Yes ☐ No

Do you have any dental questions that have never been answered satisfactorily? ☐ Yes ☐ No

____

____

Do you smoke or chew tobacco? ☐ Yes ☐ No Do you have any sores or growths in your mouth? ☐ Yes ☐ No

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated ______________ and confirm that it adequately states past and present conditions.

Date	Exceptions	NONE ☐	PATIENT'S SIGNATURE	Reviewed by
________	______________________		______________________	Dr.______________________
	______________________			
	______________________			

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated ______________ and confirm that it adequately states past and present conditions.

Date	Exceptions	NONE ☐	PATIENT'S SIGNATURE	Reviewed by
________	______________________		______________________	Dr.______________________
	______________________			
	______________________			

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated ______________ and confirm that it adequately states past and present conditions.

Date	Exceptions	NONE ☐	PATIENT'S SIGNATURE	Reviewed by
________	______________________		______________________	Dr.______________________
	______________________			
	______________________			

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated ______________ and confirm that it adequately states past and present conditions.

Date	Exceptions	NONE ☐	PATIENT'S SIGNATURE	Reviewed by
________	______________________		______________________	Dr.______________________
	______________________			
	______________________			