Dr. Stephen Kuzdenyi
Dentistry

PATIENT - INFORMATION

Last Name:_____ First Name:_____

Date of Birth:_____

Address:_____

Home Phone:_____ Cell Phone:_____
Please circle the telephone number where we can best reach you or leave a message

Email Address:_____

EMERGENCY CONTACT - INFORMATION

Last Name:_____ First Name:_____

Phone Number:_____

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to Dr. Stephen Kuzdenyi Dentistry. I understand I am financially responsible for the **PORTION NOT COVERED** by my benefits at the time of service. I also authorize Dr. Stephen Kuzdenyi Dentistry to release any information required to process my claim to my insurance company.

_____ _____
Signature of Patient (or guardian) Date

Can we leave a message on your answering machine? YES NO

PATIENT MEDICAL HISTORY

PATIENT'S NAME _____ DATE _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	☐	☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
9. DO YOU BRUISE EASILY	☐	☐
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
12. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX	☐	☐
13. DO YOU USE TOBACCO	☐	☐
14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
15. ARE YOU WEARING CONTACT LENSES	☐	☐
16. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER (PLEASE LIST) _____		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐

	YES	NO
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐

Patient Signature _____ Date: _____

REASON FOR INITIAL VISIT:

LAST DENTAL VISIT:	**LAST DENTAL CLEANING:**	**PREVIOUS DENTIST:**
Date: _____ \ _____ \ _____ M D Y	Date: _____ \ _____ \ _____ M D Y	

Please check YES or No. If not sure, please check NS.

	NO	NS	YES
Are you suffering from pain now?	☐	☐	☐
Are any of your teeth becoming loose?	☐	☐	☐
Have any of your teeth shifted?	☐	☐	☐
Does your food get caught between your teeth?	☐	☐	☐
Are any teeth sensitive to: cold ☐ hot ☐ biting ☐ pressure ☐ sweet ☐ bitter ☐			
Is there any swelling or pain of your gums?	☐	☐	☐
Is there a history of gum disease in your family?	☐	☐	☐
Are you aware of sores/growths in your mouth?	☐	☐	☐
Do you notice any bleeding from your gums when you brush your teeth, or other?	☐	☐	☐
Have you had a local anesthetic (freezing)?	☐	☐	☐
...any complications?	☐	☐	☐
Have you had any teeth extracted?	☐	☐	☐
...any complications?	☐	☐	☐
Do you have burning sensation of lips or tongue?	☐	☐	☐
Does your mouth tend to get dry?	☐	☐	☐
Do you have a bad taste in your mouth or bad breath?	☐	☐	☐
Are you nervous about having dental treatment?	☐	☐	☐
Have you ever had an upsetting experience in a Dental office?	☐	☐	☐
EXPLAIN:			

HABITS Do you -	NO	NS	YES
Clench or grind your teeth while asleep?	☐	☐	☐
Bite your lips or cheeks regularly?	☐	☐	☐
Hold foreign objects with your teeth such as pencils, pipe, pins, nails, fingernails?	☐	☐	☐
Breathe through your mouth while awake or asleep?	☐	☐	☐

	NO	NS	YES
Do you use Dental aids?	☐	☐	☐
Do you use any flouride/mouth rinses?	☐	☐	☐
Are you happy with the appearence of your teeth?	☐	☐	☐
What would you like to change about your teeth?	☐	☐	☐
How often do you brush your teeth?	☐	☐	☐
How often do you floss your teeth?	☐	☐	☐
JAW PROBLEMS Do you have any of the following?			
Clicking/popping of jaw when opening/closing?	☐	☐	☐
Pain (in jaw joints, ear, side of face)?	☐	☐	☐
Difficulty in opening or closing your mouth?	☐	☐	☐
Pain and/or difficulty in chewing?	☐	☐	☐
Pain when cleaning your teeth?	☐	☐	☐
Have you ever had implant surgery in one or both of your jaw joints?	☐	☐	☐
If yes, who performed the surgery and when was it done?	☐	☐	☐
Are you being followed-up by a dental specialist?	☐	☐	☐

TREATMENTS Please check off the following treatments you have had:	NO	NS	YES
Orthodontic treatment (braces) ?	☐	☐	☐
Oral Surgery?	☐	☐	☐
Periodontal treatment (gum surgery) ?	☐	☐	☐
Teeth ground or bite adjustment?	☐	☐	☐
Worn a bite plate or other appliance?	☐	☐	☐
Dental implants?	☐	☐	☐

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist to perform necessary diagnostic proceedures and treatment, including general or local anesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be inclusive. I know that your office has a privacy code, and I can ask to see the code at any time. I agree that your office can collect, use and disclose personal information about me as set out in your office privacy policy.

Patient ☐ Parent ☐ Guardian ☐ POA ☐ Date: _____ Signature: _____