DENTAL CREATIONS
Dr. Poorva Parnaik

Dental Health History *(Please print)*

Today's Date ______________

Patient Name ____ Date of Birth ______________

Please Check Yes (Y) for those that apply to you:

Y
- ❑ Sensitivity (hot, cold, sweets, pressure)
- ❑ Chipped / Broken Teeth
- ❑ Crooked or Tipped Teeth
- ❑ Loose Teeth
- ❑ Missing or Spaces Between Teeth
- ❑ Catch Food Between Teeth
- ❑ Dry Mouth or Constantly Thirsty
- ❑ Smoke or Use Chewing Tobacco

Y
- ❑ Bleeding, Swollen or Irritated Gums
- ❑ Dissatisfied with Appearance of My Teeth
- ❑ Frequent Headaches
- ❑ Jaw Joint Pain
- ❑ Grinding or Clenching Teeth
- ❑ Uncomfortable or Uneven When I Bite My Teeth Together
- ❑ Clicking or Popping of Jaw
- ❑ Difficulty Opening or Chewing

Please Check Yes (Y) or No (N) if you have, or had any of the following:

Y
- ❑ Dentures or Partials
- ❑ Braces or Clear Braces
- ❑ Periodontal Disease or Gum Treatments
- ❑ Fixed Bridge
- ❑ Dental Implants
- ❑ Crowns

Y
- ❑ Veneers
- ❑ Jaw Surgery
- ❑ Root Canals
- ❑ Sleep Apnea
- ❑ C-PAP Machine or Oral Sleep Appliance
- ❑ Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

- ❑ Make My Teeth Whiter
- ❑ Make My Teeth Straighter
- ❑ Close Spaces or Gaps That Bother Me
- ❑ Replace Dark Metal Fillings with Tooth-Colored Fillings
- ❑ Fix My Teeth So I'm Not Embarrassed When I Smile
- ❑ Repair Chipped Teeth
- ❑ Replace Missing Teeth
- ❑ Replace Old Crowns That Look Dark/Don't Match
- ❑ Have a Smile Makeover
- ❑ Stop My Jaw From Hurting or Clicking

On a scale of 1 to 10 with 10 being the highest: (Please circle)

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

If this is your first time in our office, please answer the following:

Date of last cleaning? ______ / ______ Date of last oral cancer screening? ______ / ______

Date of last complete x-rays? ______ / ______

What is the most important thing to you about your visit today? ______________________________

____

Why did you leave your previous dentist? ______________________________

____

DENTAL CREATIONS
Dr. Poorva Parnaik

Medical Health History *(Please print)*

Today's Date ______________

Patient Name ____ Date of Birth ______________

____
Address Email Phone

Please Check Yes (Y) or No (N) for those that apply to you:

Y N
- ❑ ❑ Anemia
- ❑ ❑ Arthritis
- ❑ ❑ Artificial Heart Valve
- ❑ ❑ Artificial Joints
- ❑ ❑ Asthma
- ❑ ❑ Blood Disease
- ❑ ❑ Bruise Easily
- ❑ ❑ Cancer
- ❑ ❑ Chemotherapy
- ❑ ❑ Diabetes
- ❑ ❑ Dizziness
- ❑ ❑ Drug Addiction

Y N
- ❑ ❑ Emphysema
- ❑ ❑ Excessive Bleeding
- ❑ ❑ Fainting
- ❑ ❑ Glaucoma
- ❑ ❑ Heart Conditions
- ❑ ❑ Heart Lesions
- ❑ ❑ Heart Murmur
- ❑ ❑ Heart Surgery
- ❑ ❑ Hepatitis: A B C
- ❑ ❑ High Blood Pressure
- ❑ ❑ HIV Positive
- ❑ ❑ Jaundice

Y N
- ❑ ❑ Kidney Disease
- ❑ ❑ Liver Disease
- ❑ ❑ Low Blood Pressure
- ❑ ❑ Mitral Valve Prolapse
- ❑ ❑ Nervousness/Depression
- ❑ ❑ Pacemaker
- ❑ ❑ Periodontal Disease
- ❑ ❑ Radiation (Head/Neck)
- ❑ ❑ Respiratory Problems
- ❑ ❑ Rheumatic Fever
- ❑ ❑ Rheumatism
- ❑ ❑ Scarlet Fever

Y N
- ❑ ❑ Seizures
- ❑ ❑ Stomach Problems
- ❑ ❑ Stroke
- ❑ ❑ Thyroid Disease
- ❑ ❑ Tuberculosis
- ❑ ❑ Ulcers
- ❑ ❑ STD ______________
- ❑ ❑ Other______________

Women Only
- ❑ ❑ Birth Control
- ❑ ❑ Nursing
- ❑ ❑ Pregnant

Delivery Date: __________

Do you have any of the following drug allergies?

Y N
- ❑ ❑ Aspirin
- ❑ ❑ Codeine
- ❑ ❑ Darvon
- ❑ ❑ Erythromycin

Y N
- ❑ ❑ Latex
- ❑ ❑ Anesthetic
- ❑ ❑ Nitrous Oxide
- ❑ ❑ Sulfa

Y N
- ❑ ❑ Percodan
- ❑ ❑ Penicillin
- ❑ ❑ Antibiotics
- ❑ ❑ Valium

Please list other allergies:
____
____
____

Please Check Yes (Y) or No (N) if you have taken any of the following drugs at any time:

Y N
- ❑ ❑ Fosamax
- ❑ ❑ Aredia

Y N
- ❑ ❑ Didronel
- ❑ ❑ Actonel

Y N
- ❑ ❑ Zometa
- ❑ ❑ Skelid

Y N
- ❑ ❑ Boniva
- ❑ ❑ Bisphosphonates

Please list ALL medications you currently take: *(Prescription & Over-the-Counter. Attach List if Needed)*

______________________ ______________________ ______________________
______________________ ______________________ ______________________

Please list all surgeries with approximated dates: ______________________________
____
____

Is there any other information regarding your past medical history we should know about?__________
____

If under a physician's care, please explain:____________________________________
____

Physician's Name ______________________________Physician's Phone: ______________

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify Dental Creations, LLC of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Dental Creations, LLC or its employees liable in the event of death or injury.

Patient or Guardian Signature:____________________Date: ____________Dentist Signature:____________________

Patient Information

Patient's Name ____ Date______/_____/______
Last First Middle
Address____
Street City State Zip
Home Phone _________________ Work Phone _________________ Cell Phone _________________
Birth Date___/___/____ Social Security # ________________
Email Address _________________________________ May we contact you by email? ☐Yes ☐ No
Employer _____________________ Occupation ____________________ # Years Employed_______
Responsible party's name: _______________________________________ Birth Date____/____/____
Relationship to patient _____________ Occupation ______________ Social Security # ____________
Address____
Street City State Zip
How did you hear about us? ☐Friend/Family ___________ ☐Internet ☐Drive-by ☐Other: _________

Insurance Information

Insured's Name____
Insured's Birth Date______/______/______ Insured's Soc Sec # _______________________________
Insurance Company __________________________ Group # ______________ ID # ______________
Insurance Co. Address _______________________________________Phone # _________________

Spouse Information

Spouse's Name _____________________________________Relationship to Patient ______________
Employer_____________________________ Occupation_______________No. Years Employed_____
Social Security # ______________________ Birth Date_______________ Work Phone____________

Emergency Information

Name of nearest relative not living with you ____
Address____
Street City State Zip
Contact phone # __________________________ Relationship _________________________________

Visit our website Medfordentist.com for detailed information and videos of our procedures.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
Please initial after reading each of the following:

— I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to Third Party Payor.

— I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

— **I understand that due to the restrictions placed by my insurance company on the level of benefits in the policy purchased by me/my employer, MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR THE SERVICES. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.**

— **All patients with Horizon Dental Insurance must pay in FULL for treatment at the time of service and will be reimbursed by their insurance company.**

Signature (Parent or Guardian's signature if minor)____________________________________

Printed Name____