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Natural Smile Dentistry
Priya Mainker, DMD

Family, Pediatric and Cosmetic Dentistry
Invisalign Orthodontics

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Preferred or Nick Name	Gender Circle one
				Male Female
Soc Sec Num NNN-NN-NNNN	**Date of Birth MM/DD/YYYY**	**Marital Status Circle one**	**Email Address**	**Drivers License Number**
- -	/ /	SINGLE MARRIED OTHER		
Home Address				
Street	**City**	**Zip, State**	**Phone Number**	**Alternate Phone**
Work Address				
Street	**City**	**Zip, State**	**Phone Number**	**Alternate Phone**
Emergency Contact				
Name	**Relationship**	**Phone Number**	**Alternate Phone**	**Work Number**

INSURANCE INFORMATION

Primary Insured Person				
Last Name	**First Name**	**Middle Initial**	**Soc Sec Num**	**Date of Birth**
			- -	/ /
Employer of the Primary Insured				
Company Name	**Street Address**	**City**	**State & Zip**	**Phone Number**
Insurance Plan				
Insurance Carrier	**Street Address**	**City, State, Zip**	**Phone Number**	**Group Number**
Secondary Insurance Plan (Leave Blank if there is no secondary insurance)				
Insurance Carrier	**Street Address**	**City, State, Zip**	**Phone Number**	**Group Number**

Assignment of benefits and signature on file

I hereby assign to Dr. Priya Mainker, Natural Smile Dentistry, P. A., payment of insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.	I authorize release of any information related to insurance claims filed on my behalf by Dr. Priya Mainker, Natural Smile Dentistry P. A.

I understand that in case I cancel or reschedule my appointment at less than 24 hours notice, there may be a fee charged to me.

Please provide your drivers license, or other form of identification, and your insurance card(s) along with the completed form.

Today's Date	Print Name	Signature

How did you find out about Natural Smile Dentistry (Check the appropriate box and provide relevant info)				
☐Internet search. Site: Phrase:	☐Insurance Company. Name:	☐Referred by patient. Name:	☐Referred by another health care provider. Name:	☐Other. Please Specify:

ADA® Health History Form

Medical Alert	Condition	Premedication	Allergies	Anaest.	Date

Name ______________________ (Last / First / Middle) Home Phone ( ) ______ Business Phone ( ) ______

Address ______________________ (P.O. Box or Mailing address) City ______ State ______ Zip Code ______

Occupation ______________________ Height ______ Weight ______ Date of Birth ___/___/___ Sex ☐ M ☐ F

SS# ______________ Emergency Contact ______________ Relationship ______________ Phone ( ) ______

If you are completing this form for another person, what is your relationship to that person? ______________ (Name / Relationship)

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

Yes	No	Don't Know	
☐	☐	☐	Do your gums bleed when you brush?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?
☐	☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain ______________

How would you describe your current dental problem? ______________

Date of your last dental exam ______________ Date of last dental x-rays ______________

What was done at that time? ______________

How do you feel about the appearance of your teeth? ______________

Medical Information

Yes	No	Don't Know	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems: **If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.**

Yes	No	Don't Know	
☐	☐	☐	Active Tuberculosis
☐	☐	☐	Persistent cough greater than a 3 week duration
☐	☐	☐	Cough that produces blood
☐	☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? ______________ Date of last physical examination ______________

Physician(s) ______________ (NAME / PHONE / ADDRESS / CITY/STATE/ZIP)

______________ (NAME / PHONE / ADDRESS / CITY/STATE/ZIP)

Yes	No	Don't Know	
☐	☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? ______________
☐	☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking?

Prescribed ______________

Over the counter ______________

Natural or herbal preparations ______________

Yes	No	Don't Know	
☐	☐	☐	Have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? ______ In the past month? ______ If yes, ______# of drinks per day for ______# of years
☐	☐	☐	Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ☐ Yes ☐ No
☐	☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list ______ Frequency of use (daily, weekly, etc.) ______ Number of years of recreational drug use ______
☐	☐	☐	Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) ☐ Very ☐ Somewhat ☐ Not interested
☐	☐	☐	Do you wear contact lenses?

Allergies Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No	Don't Know	
☐	☐	☐	Local anesthetics
☐	☐	☐	Aspirin
☐	☐	☐	Penicillin or other antibiotics
☐	☐	☐	Barbiturates, sedatives, or sleeping pills
☐	☐	☐	Sulfa drugs
☐	☐	☐	Codeine or other narcotics
☐	☐	☐	Latex
☐	☐	☐	Iodine
☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Animals
☐	☐	☐	Food (Specify) ______________
☐	☐	☐	Other (Specify) ______________

To yes responses, specify type of reaction ______________

Yes	No	Don't Know	
(Women Only)			
☐	☐	☐	Are you pregnant?
☐	☐	☐	Nursing?
☐	☐	☐	Taking birth control pills?
☐	☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so when was this operation done? ______
☐	☐	☐	Have you had any complications or difficulties with your prosthetic joint?
☐	☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose?

Name of physician or dentist* ______ Phone ______

NOTE TO PATIENT: A new report (July 1997) prepared and endorsed by the American Dental Association and the American Academy of Orthopaedic Surgeons has recommended that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with artificial orthopedic prosthetic joints. This office will be glad to discuss this report with you and provide a copy of it to you and your orthopedic surgeon/physician.

Please (X) if you have or had any of the following diseases or problems.

Yes	No	Don't Know	
☐	☐	☐	Abnormal bleeding
☐	☐	☐	AIDS or HIV infection
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatoid arthritis
☐	☐	☐	Asthma
☐	☐	☐	Blood transfusion If yes, date ______
☐	☐	☐	Cancer/chemotherapy/radiation treatment
☐	☐	☐	Cardiovascular disease. If yes, specify below: ○ Angina ○ Arteriosclerosis ○ Artificial heart valves ○ Coronary insufficiency ○ Coronary occlusion ○ Damaged heart valves ○ Heart attack ○ Heart murmur ○ High blood pressure ○ Inborn heart defects ○ Mitral valve prolapse ○ Pacemaker ○ Rheumatic heart disease
☐	☐	☐	Chest pain upon exertion
☐	☐	☐	Chronic pain
☐	☐	☐	Persistent diarrhea
☐	☐	☐	Disease, drug, or radiation-induced immunosurpression
☐	☐	☐	Diabetes. If yes, specify below: ○ Type I (Insulin dependent) ○ Type II
☐	☐	☐	Dry mouth
☐	☐	☐	Eating disorder. If yes, specify ______
☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	G.E. reflux
☐	☐	☐	Glaucoma
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	☐	Recurrent infections Indicate type of infection ______
☐	☐	☐	Kidney problems
☐	☐	☐	Low blood pressure
☐	☐	☐	Mental health disorders. If yes, specify below: ______ ______
☐	☐	☐	Malnutrition
☐	☐	☐	Migraines
☐	☐	☐	Night sweats
☐	☐	☐	Neurological disorders. If yes, specify ______
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands in neck
☐	☐	☐	Respiratory problems. If yes, specify below: ○ Emphysema, ○ Bronchitis, etc.
☐	☐	☐	Severe headaches
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Sinus trouble
☐	☐	☐	Sleep disorder
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke
☐	☐	☐	Systemic lupus erythematosus
☐	☐	☐	Thyroid problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination
☐	☐	☐	Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain: ______ ______ ______

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

______
Signature of Patient/Legal Guardian Date

For completion by dentist

Comments on patient interview concerning health history ______

______

______

Significant findings from questionnaire or oral interview ______

______

______

Dental management considerations ______

______ ______
Signature of Dentist Date

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist

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