Mark H. Zablotsky, D.D.S.

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NEW PATIENT INFORMATION RECORD

NAME _____ / / _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ ZIP _____ HOME TEL NO _____

EMPLOYER _____ OCCUPATION _____ BUS TEL NO _____

SSN _____ E-MAIL ADDRESS _____ CELL PHONE NO _____

REFERRED BY _____ YOUR DENTIST _____ PREVIOUS DENTIST _____

MARITAL STATUS _____ SPOUSES NAME _____

SPOUSES BUS TEL NO _____ SPOUSES SSN _____

EMERGENCY CONTACT (not spouse) _____ PHONE NO _____

MY DENTAL INSURANCE INFORMATION

INSURANCE CO _____

GROUP DENTAL PLAN NAME _____

POLICY NO _____ UNION NO _____

EMPLOYER _____

OCCUPATION _____

MY SPOUSE'S DENTAL INSURANCE INFORMATION

INSURANCE CO _____

GROUP DENTAL PLAN NAME _____

POLICY NO _____ UNION NO _____

EMPLOYER _____

OCCUPATION _____

☐ I AM NOT COVERED BY ANY DENTAL INSURANCE (EITHER MINE OR OTHER FAMILY MEMBERS) AT THIS TIME

I hereby authorize Mark Zablotsky, D.D.S. or his staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Dr. Zablotsky of the medical and dental insurance benefits otherwise payable to me, for the services rendered to me by either doctor or his staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Academy of Periodontology, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Mark Zablotsky, D.D.S.

Appointments: Your appointment time is reserved for you. We will do our best to be prompt and to estimate the time of your visit, but emergencies do arise. Please allow enough time for us to do our best dentistry for you. We believe that quality is more important than speed. There is a charge for missed appointments or cancellations without 72 hours notice.

I acknowledge that I have read and understand the above statements and policies, and that this authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____

Signature of Patient or Patient's Legal Guardian Date of Signature

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question.

1. How frequently do you visit your dentist? _____
2. When did you last have your teeth cleaned? _____
3. Have you ever had any teeth extracted? _____

   How long ago? _____ Which areas? _____

   Why? _____

   Any associated bleeding or healing problems? _____
4. Have you ever had orthodontic treatment? (teeth straightened) _____

   If so, when? _____
5. When were you first made aware that you had periodontal (gum) problems? _____
6. Have you ever had periodontal (gum) treatment? _____

   When? _____

   What treatment was performed? _____

   _____
7. Have you ever had endodontic (root canal) treatment? _____
8. Do you have any removable partials? _____

   How many years? _____

   Is it or are they comfortable? _____
9. Would you be greatly disturbed if you had to lose all your natural teeth and wear false teeth? _____
10. Did either of your parents lose all of their natural teeth? _____
11. Are you dissatisfied with the appearance of your teeth? _____

    Why? _____
12. Are there any foods you cannot chew? _____

    Which? _____
13. Have you noticed any loose teeth? _____

    Where? _____
14. Have any of your teeth recently separated, creating spaces between them? _____

    Where? _____
15. Does food wedge between any of your teeth? _____

    Where? _____
16. Are your teeth sensitive to cold, heat or sweets? _____

    Which? _____

    Where? _____
17. Do your gums ever bleed? _____

    When? _____
18. Have you noticed any bad odors or tastes from your mouth? _____
19. Have you ever had Vincent's infection or trench mouth? _____

    When? _____
20. How often do you brush your teeth? _____

    _____ times per day

    When? _____
21. Do you use a hard, medium or soft bristle brush? _____

    Which? _____
22. Do you daily use dental floss, rubber tip or Stimudents? _____

    Which? _____
23. Do you use anything else to clean your teeth? _____

    If so, what? _____
24. Have you ever had oral hygiene instruction? _____
25. Does your jaw click when you chew? _____
26. Is it difficult to open your mouth as wide as you would like? _____
27. Do you ever have pain in the region in front of your ears? _____
28. Do you clench, grit or grind your teeth in the daytime or while you are sleeping? _____

    Do you wear a nightguard or splint? _____
29. Do you have any habits, such as biting your nails, chewing on pipe or pencil, etc.? _____
30. Have you been under more than average nervous tension lately?

    _____
31. Is your mouth dry in the morning when you awaken? _____
32. Do you breathe through your mouth much of the time? _____
33. How long have you been a patient of your current dentist? _____

WOMEN ONLY

Are you pregnant? _____

Are you nursing? _____

Are you taking birth control pills? _____

Have you undergone, or are you undergoing menopause? _____

MEDICAL HEALTH QUESTIONNAIRE

(This information is necessary for our files and your health and will be considered confidential)

YOUR MEDICAL DOCTOR'S NAME _____ YOUR AGE _____ HEIGHT _____ WEIGHT _____

CITY _____ TEL. NO. _____ FAX NO. _____ YOUR LAST MEDICAL EXAM WAS IN (MONTH) _____

DATE OF LAST PHYSICAL EXAM _____

	YES	NO
HAVE YOU BEEN A PATIENT IN A HOSPITAL DURING THE PAST TWO YEARS?	❑	❑
HAVE YOU BEEN UNDER A DOCTOR'S CARE DURING THE PAST TWO YEARS?	❑	❑
DO YOU TAKE ANY MEDICINES OR DRUGS? (INCLUDING ASPIRIN, VITAMINS, HORMONES, ANTACIDS?)	❑	❑
IF SO, LIST HERE: _____		
ARE YOU ALLERGIC TO PENICILLIN OR ANY OTHER MEDICINES OR DRUGS?	❑	❑
IF SO, WHAT TYPE REACTION DID YOU HAVE? _____		
DOES ASPIRIN OR IBUPROFEN (MOTRIN) IRRITATE YOUR STOMACH?	❑	❑
HAVE YOU EVER HAD ANY ADVERSE REACTIONS TO ANY DRUGS, ANESTHETICS, SEDATIVES OR NARCOTICS?	❑	❑
HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT?	❑	❑
HAVE YOU BEEN DIAGNOSED AS HAVING ANY IMMUNODEFICIENCY, ARC OR AIDS?	❑	❑
DO YOU WEAR CONTACTS?	❑	❑
IS THERE A HISTORY OF DIABETES IN YOUR FAMILY?	❑	❑
IF SO, WHO? _____		
ARE YOU REQUIRED, DUE TO YOUR HEALTH, TO RESTRICT YOUR WORK OR ACTIVITY IN ANY WAY?	❑	❑
ARE YOU ON A RESTRICTED DIET OF ANY KIND?	❑	❑
DO YOU USE TOBACCO? _____ IF SO, HOW MUCH PER DAY? _____ AND FOR HOW LONG? _____ YRS.		
DO YOU DRINK ALCOHOL? _____ IF SO, HOW MUCH PER DAY? _____		
DO YOU HAVE ANY HISTORY OF ANY TYPE OF SUBSTANCE ABUSE?	❑	❑
HAVE YOU EVER TAKEN FEN/PHEN OR REDUX?	❑	❑

CHECK ANY OF THE FOLLOWING WHICH YOU MAY HAVE HAD:

❑ HEART TROUBLE	❑ HIGH BLOOD PRESSURE	❑ PERSISTENT COUGH	❑ HISTORY OF CANCER
❑ CONGENITAL HEART LESIONS*	❑ LOW BLOOD PRESSURE	❑ SINUS TROUBLES	❑ RADIATION THERAPY
❑ HEART MURMUR* OR ENDOCARDITIS	❑ GLAUCOMA	❑ TUBERCULOSIS	❑ CHEMOTHERAPY
❑ PROLAPSED MITRAL VALVE*	❑ DIABETES	❑ ASTHMA	❑ THYROID PROBLEMS
❑ HEART SURGERY	❑ HEPATITIS OR JAUNDICE	❑ EPILEPSY	❑ LATEX ALLERGY
❑ RHEUMATIC FEVER*	❑ ULCERS	❑ ARTHRITIS	❑ _____
❑ CARDIAC PACEMAKER	❑ KIDNEY DISEASE*	❑ STROKE	
❑ HEART VALVE PROSTHESIS*	❑ PSYCHIATRIC CARE	❑ JOINT REPLACEMENT SURGERY	

*HAS A PHYSICIAN DIRECTED YOU TO TAKE ANTIBIOTICS PRIOR TO HAVING YOUR TEETH CLEANED? ❑ YES ❑ NO

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU FEEL WE SHOULD KNOW ABOUT? ❑ YES ❑ NO

IF SO, PLEASE EXPLAIN: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____ DATE: _____ REVIEWED BY: _____

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