



S. Mirfendereski, D.D.S.
65 East State St.
Columbus, OH 43215

PATIENT INFORMATION:

Patient Name (Last) _____ (First) _____ (Mr., Mrs., Miss, Ms.) _____
Home Phone _____ Work Phone (Where Permitted) _____ Spouse's Name _____
Street Address _____ City _____ St. _____ Zip _____
Social Sec. No. _____ Date of Birth _____ Spouse's S.S. No. _____ Spouse's Date of Birth _____
Employer's Name _____ Spouse's Employer Name _____
Address _____ Address _____
City, St., Zip _____ City, St., Zip _____
Primary Insurance Carrier _____ Secondary Insurance Carrier _____
Address _____ Address _____
City, St., Zip _____ City, St., Zip _____

Who referred you to our office? _____

DENTAL HISTORY:

Is there anything about your mouth that concerns you now? _____
How long has it been since you've seen a dentist? _____
What was done then? _____
Did you have X-rays? _____
How often did you visit before that? _____ Have you lost any teeth? _____
Where in your mouth? _____ Why were they lost? _____
Did you have them replaced? _____ Did anyone recommend replacement? _____
Have you ever had root canal treatment? _____ Have you ever had braces? _____
How do you take care of your teeth? _____
Do your gums ever bleed? _____ Do you eat between meals? _____
What? _____ Do you brush? _____
Does food wedge between your teeth? _____ Where? _____
Do you feel you have unpleasant breath at times? _____
Do you have unpleasant taste in your mouth? _____
Are you aware of grinding or clenching your teeth? _____
Are you aware of popping, clicking or snapping noises when you chew or open/close your mouth? _____
Do you have headaches? _____ How often? _____
Where? _____ Do you have earaches? _____
Do you have ringing in your ears? _____
Are you aware of sore muscles in your jaw or side of your head? _____
Do you have any fears about dentistry? _____ What are they? _____
What could we do to make you comfortable? _____
How do you feel about your teeth? _____
How do you feel about dentures? _____
Appearance : Recognition / Comfort / Self-preservation / Investment

MEDICAL HISTORY:

Many medical conditions may affect the treatment we can do for you. Have you had any of the following?

- _____ Heart Condition
- _____ High Blood Pressure
- _____ Low Blood Pressure
- _____ Circulatory (blood) Condition
- _____ Cancer
- _____ Asthma
- _____ Radiation Therapy
- _____ Arthritis
- _____ Diabetes
- _____ Hepatitis
- _____ Rheumatic Fever
- _____ Sinus Condition
- _____ Stroke
- _____ Psychiatric Care
- _____ Typhoid Fever
- _____ Kidney Condition
- _____ Liver Condition
- _____ Tuberculosis
- _____ Veneral Disease
- _____ Ulcers
- _____ Nervous Condition
- _____ Hospitalization
- _____ HIV
- _____ Other

Allergies to: Drugs _____ Anaesthetics _____
Food _____ Other _____
Are you taking any Medications now? _____ Are you Pregnant? _____
Physician's Name _____ Blood Pressure S _____ / D _____ / _____

AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Patient Signature: _____ Date: _____
Reviewed by: Doctor _____ Date: _____
FOR OFFICE USE ONLY
B/P _____