



PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME: _____ (FIRST) _____ (LAST) _____ (MI) _____ (Preferred name)

GENDER: Male Female STATUS: single married child other

SPOUSE'S NAME: _____

DATE OF BIRTH: ____/____/____ Age: ____ SS#: ____--____--
month day year

Driver's License #: _____

HOME ADDRESS: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: () _____ WORK #: () _____ Ext. _____

CELL #: () _____ E-MAIL ADDRESS: _____

We provide all our patients with e-mail and text message appointment reminders. If you wish NOT to receive any of these services please check the box/s below (*your e-mail address as well as other personal information is for office use only and will not be shared with third parties.*):

Please DO NOT text message me.

Please DO NOT e-mail me.

EMPLOYER: _____ How long have you been employed with this company? _____

EMPLOYER'S ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ OCCUPATION: _____

HOW DID YOU LEARN ABOUT OUR DENTAL OFFICE? (*Please check one of the boxes below*)

Internet

Driving by

Phone Book

Word of mouth

Friend (*Name: _____*)

Relative: (*Name: _____, relation: _____*)

EMERGENCY CONTACT

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

HOME #: () _____ WORK #: () _____ Ext. _____

CELL #: () _____ OTHER #: () _____

YOUR MEDICAL DOCTOR: _____ DOCTOR'S PHONE #: () _____

6325 Topanga Canyon Blvd, Ste 515
Woodland Hills, California 91367
818 - 999 - 0104

SYMPTOMS Have you experienced any of the following in the last 3 months?

Chest pain (angina)	Diarrhea	Jaundice
Fainting spells	constipation	Dry mouth
Unexplained weight loss	Frequent urination	Excessive thirst
Fever	Ringling in ears	Difficulty swallowing
Night sweats	Headaches	Swollen neck glands
Persistent cough	Dizziness	Swollen ankles
Coughing up blood	Bruise easily	Joint pain, stiffness
Shortness of Breath	Frequent vomiting	Sinus problems

CONDITIONS Have you had or do you have any of the following? (Please circle Yes or No for each)

Artificial joints (Type_____Year_____)	Seizures	Tuberculosis
Heart disease	Cosmetic surgery	Kidney or bladder disease
Family history of heart disease	Surgeries	Eating disorders
Heart attack	Ulcers	Osteoporosis
Heart defects	Diabetes	Thyroid disease
Heart murmurs	Family history of diabetes	Hepatitis (Type_____)
Pacemaker	Tumors	Sexual transmitted disease
Artificial heart valve	Cancer	Herpes
Hardening of arteries	Chemotherapy	Canker or cold sores
High blood pressure	Radiation	Anemia
Low blood pressure	Arthritis, rheumatism	Liver disease
Stroke	Emphysema or other lung disease	Glaucoma
Rheumatic fever	Asthma	Transplant

CONDITIONS CONTINUED... This information will not be released unless specifically authorized by patient.
(Please circle Yes or No for each)

HIV	Treatments for emotional condition
Anxiety	Depression

ALLERGIES Are you allergic to or have you had a reaction to any of the following?
(Please circle Yes or No for each)

Aspirin	Penicillin	Metal
Darvon	Amoxicillin	Novocain or Xylocaine
Valium	Sulfa	Latex
Demerol	Erythromycin	Iodine
Codeine	Tetracycline	Acrylic
Vicodin	Food (type_____)	
Percodan	Nitrous Oxide	

Please list any other medications or substances you are or may be allergic to: _____

Name: _____

MEDICATIONS / SUBSTANCES 3 Are you taking or have you taken any of the following in the last months? (Please mark Yes or No for each)

Antibiotics	Supplements	Recreational drugs.
Over-the-counter medicines	Aspirin Daily	Tobacco in any form
Weight loss medications	Blood Thinners (Coumadin)	Alcohol
Corticosteroids	Bisphosphonate (Fosamax)	

Please list all medications you are currently taking: _____

WOMEN ONLY (Please mark Yes or No for each)

- Yes / No Are you taking birth control pills?
- Yes / No Are you or could you be pregnant? If YES, what month? _____
- Yes / No Are you nursing?

ALL PATIENTS (Please mark Yes or No for each)

- Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
- If YES, explain: _____
- Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____
- Yes / No Have you ever taken Pondimin or Fen-Phen? If YES, when: _____
- Yes / No Are you a smoker? If YES, how much do you smoke per day? How long have you smoked? _____

ALL PATIENTS - SLEEP ASSESSMENT (Please mark Yes or No for each)

- Yes / No Have you ever been told you stop breathing while asleep?
- Yes / No Have you ever fallen asleep or nodded off while driving?
- Yes / No Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
- Yes / No Do you feel excessively sleepy during the day?
- Yes / No Do you snore, or have you ever been told that you snore?
- Yes / No Have you had weight gain and found it difficult to lose?
- Yes / No Have you taken medication for, or been diagnosed with high blood pressure?
- Yes / No Do you kick or jerk your legs while sleeping?
- Yes / No Do you feel burning, tingling or crawling sensations in your legs when you wake up?
- Yes / No Do you wake up with headaches during the night or in the morning?
- Yes / No Do you have trouble falling asleep?
- Yes / No Do you have trouble staying asleep once you fall asleep?

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The practice of dentistry involves treating the whole person. If Dr. Solow determines that there may be a medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

Do you authorize Dr. Solow and/or his staff to contact your physician if necessary? YES NO

Physician's Name: _____ Office phone #: _____

ROBERT M. SOLOW, D.D.S., INC. – DENTAL PRACTICE POLICES

- We invite you to discuss with us any questions regarding our services. We are best able to address your dental needs, desires and concerns when there are open communications to assure mutual understanding between you and our staff.
- The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my or my child's medical status. I authorize the dental staff to perform necessary dental services for me/ my minor/child.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our business manager. In the absence of a preexisting financial arrangement, if your account is greater than 90 days past due, you may be held liable for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your account.
- In an effort to improve patient scheduling and care, we respectfully request that you advise us of your need to cancel or change your appointment at least **24 hours** prior to your reserved time. Please extend this courtesy both to us and to other patients who may benefit from your appointment time. If you find it necessary to change or cancel an appointment at the last minute, there will be a charge of **\$45.00** for each hour of appointed time. While we understand that unforeseen emergencies and illness may occur, we ask that you consider the value of our time and the needs of other patients.
- I certify that I have read and understand the above statements of Office Policy and Health History which I completed. I have answered each question accurately and to the best of my knowledge. I will continue to inform this office and staff of any change in my health status and/or medication. I also consent to Dr. Solow's office using my cell phone to contact me regarding any appointments, insurance information or account matters. Further, I will not hold Dr. Solow, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____
(Signature of legal Guardian or Parent if Patient is under 18 years of age)

MEDICAL UPDATES (Office use only)

<u>Date</u>	<u>Changes to Health History</u>	<u>Dentist or Hygienist Initials</u>