# *Dr. Dana Ghorab, DDS, PC*

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*www.talegadentist.com*

*Our goal is to help you reach and maintain optimal oral health.*

*Please fill out this form completely. The better we communicate, the better we can care for you.*

## ***About You***

Name:_____
Last First Mi

I prefer to be called:_____

□ Male □ Female Birthdate: _____/_____/_____Age:_____

□ Single □ Married □ Divorced / Separated □ Partnered

HM #: (_____)-_____-_____ Cell/Other #: (_____)-_____-_____

E-mail: _____

Address: _____

_____

_____

How would you like to be contacted to confirm appointments?

□Text Message □ E-mail □Phone: _____

Whom may we thank for referring you? _____

Previous / Present Dentist: _____

Have you had problems with prior dental treatment or are you anxious?

_____

_____

Would you like to watch TV during treatment? □ Yes □ No

If yes, what channels?_____

**Person Responsible for Account:** _____

## ***Insurance***

**Primary Insurance**

Dental Coverage? □ Yes □ No
Insurance Co. Name:_____
Insurance Co. Phone:_____
Group # (Plan or Policy #):_____
Insured's Name:_____
Relationship:_____
Birthdate:____/____/_____
ID #:_____
Employer:_____
Employer Address:_____
_____
City State Zip

**Secondary Insurance**

Dental Coverage? □ Yes □ No
Insurance Co. Name:_____
Insurance Co. Phone:_____
Group # (Plan or Policy #):_____
Insured's Name:_____
Relationship:_____
Birthdate:____/____/_____
ID #:_____
Employer:_____
Employer Address:_____
_____
City State Zip

# Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's name:_____

Phone #:(__)_____Date of Last visit:____/____/____

**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:_____

Have you or do you now smoke or use tobacco in any form?

☐ Yes ☐ No Please explain: _____

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

**Are you taking any medication?** ☐ Yes ☐No

Please list each one: _____

_____

Have you ever taken Phen– Fen?

(Also known as Redux or Pondimin?) ☐ Yes ☐ No

Have you ever taken Bisphosphonates? ☐ Yes ☐ No

**For Women:**

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

**Have you ever had any of the following diseases/medical problems?**

Y N Acid Reflux
Y N AIDS/HIV positive
Y N Alcohol/Drug Abuse
Y N Anaphylaxis
Y N Anemia
Y N Arthritis, Rheumatism
Y N Artificial heart valves
Y N Artificial joints
Y N Asthma
Y N Atopic (Allergy prone)
Y N Back problems
Y N Blood Transfusion
Y N Blood Disease
Y N Cancer
Y N Chemotherapy/Radiation
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Other: _____

Y N Hay Fever
Y N Heart Attack / Surgery
Y N Heart Murmur
Y N Hepatitis (A) (B) (C)
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Liver Disease
Y N Lupus
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease
Y N Sleep Apnea

**Are you allergic to any of the following?**

**Y N** Aspirin
**Y N** Codeine
**Y N** Dental Anesthetics
**Y N** Erythromycin
**Y N** Jewelry/Metals

**Y N** Latex
**Y N** Penicillin
**Y N** Tetracycline
**Y N** Vicodin
**Y N** Other _____

# Dental History

**What brings you to the dentist today?** _____

_____

**When was your last dental visit and x-rays?** _____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

**Your current dental health is:** ☐ Good ☐ Fair ☐ Poor

☐ Yes ☐ No Sensitivity to cold / hot

☐ Yes ☐ No Sensitivity to sweets

☐ Yes ☐ No Sensitivity when biting

☐ Yes ☐ No Do you have pain or clicking/popping jaw?

☐ Yes ☐ No Grinding or Clenching teeth

☐ Yes ☐ No Bleeding Gums

☐ Yes ☐ No Have you had a deep cleaning or periodontal surgery?

☐ Yes ☐ No Food collection between teeth

☐ Yes ☐ No Orthodontic treatment/Braces – When? _____

How often do you brush? _____

Is there anything not mentioned on this form? _____

Do you Floss Daily? ☐ Yes ☐ No

Are you interested in any of the following?
□ Teeth Whitening □Tooth-colored fillings □ Orthodontic Treatment
□ Dental Implants □ Invisalign □ Veneers
□ How to prevent Periodontal Disease
□ Oral Hygiene for infants and toddlers

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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____
Signature Date

# Office Use Only

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's comments: _____

_____

_____

_____