THE KODISH-PEREZ
DENTAL GROUP

Please check ✓ all that apply.

Are you having pain or discomfort at this time? _____ Yes__ No__
Have you been a hospital patient in the last two years? _____ Yes__ No__
Are you currently under the care of a physician? _____ Yes__ No__

Physician's Name: _____ Specialty: _____

Physician's Address:_____ Office Phone: _____

Are you taking medication at the present time? : _____ Yes__ No__
If yes, please list the medications and their daily dosages:
_____

_____

Are there any medications that **you should be taking**, but are not taking? _____ Yes__ No__
If yes, please explain: _____

Are you allergic to (i.e. itching, rash, swelling, etc.) or have you ever been made sick by:

_Penicillin _Aspirin _Codeine _Sulfa _Acetaminophen
_Lidocaine (Novocaine) _Ibuprofen

Other? Please explain _____
Have you had any excessive bleeding requiring special treatment? _____ Yes__ No__
Do you currently smoke cigarettes, pipes, or cigars? _____ Yes__ No__
*If yes, would you consider a smoking cessation program?*_____ Yes__ No__
Do you chew smokeless tobacco? _____ Yes__ No__
Do you consume more than three alcoholic beverages each day? _____ Yes__ No__
Are you presently taking antidepressants?_____ Yes__ No__
Which antidepressant? _____
Do you take over the counter medication or herbal supplements on a regular basis? Yes__ No__
*If yes, please list:*_____
WOMEN: Are you pregnant? _____ Yes__ No__
*If yes, when are you expecting?*_____
Are you being treated for osteoporosis? _____ Yes__ No__
*If yes, is it an injection or pills?*_____
What is the name of the osteoporosis medication?_____
Do you snore? _____ Yes__ No__
*If yes, have you been diagnosed or treated for a sleep disorder (sleep apnea)?*__ Yes__ No__

I understand that several substances including, but not limited to, anabolic steroids, cocaine, excessive alcohol consumption, etc., may have dangerous and even fatal effects when combined with dental anesthetics. I will always disclose any potentially significant information to Dr. Perez and his team.

_____ _____ _____
Patient Signature Patient Printed Name Date

Please check any of the following that you have had in the past or currently have:

_Heart Failure
_Heart Disease
_Heart Attack
_Angina Pectoris
_High Blood Pressure
_Low Blood Pressure
_Heart Murmur
_Rheumatic Fever
_Scarlet Fever
_Heart Pacemaker
_Heart Surgery
_Anemia
_Sickle Cell Anemia
_Ulcers
_Stomach Disease
_Thyroid
_Diabetes
_Bulimia
_Stroke
_Fainting/Dizzy Spells
_Intestinal Disorder
_Hypertrophic Cardiomyopathy
_Mitral Valve Prolapse (MVP) **with** valvular regurgitation
_Mitral Valve Prolapse (MVP) **without** valvular regurgitation
_Pneumonia
_Emphysema
_Tuberculosis
_Asthma
_Sinus Trouble
_Glaucoma
_Allergies/Hives
_Syphilis/Gonorrhea
_Alcoholism
_Benign Growth
_Carcinoma
_Chemotherapy
_Radiation Therapy
_Scleroderma
_Nervousness
_Pain in Jaw Joints
_Candida Albicans
_Anorexia Nervosa
_Cold Sores
_Canker Sores
_Congenial Heart Malformation
_Prosthetic Heart Valves
_Hepatitis A (Infectious)
_Hepatitis B (Serum)
_Hepatitis C
_Hepatitis (another form)
_Yellow Jaundice
_Drug Addiction
_Blood Transfusion
_Liver Disease
_Anabolic Steroids
_Hemophilia
_Epilepsy/Seizures
_Arthritis/Rheumatism
_Psychiatric Treatment
_HIV Positive
_AIDS
_Kaposi's Sarcoma
_Herpes (Oral/Genital)
_Lupus
_Kidney Trouble
_Intestinal Disorder
_Bacterial Endocarditis

Do you have any disease, condition, or problem not listed? _____ Yes __No
*If yes, please explain:*_____
_____

Have you ever had any plastic surgery? _____ Yes __No
If yes, please explain: _____
_____

I authorize the release of any information upon the written request of a third party payer or health care practitioner. I fully understood the questions asked on these forms. To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health status, I will always inform Dr. Perez, Dr. Kodish and their team prior to or at my next appointment.

_____ _____ _____
Patient Signature Patient Printed Name Date

THE KODISH-PEREZ
DENTAL GROUP

Dental History Page 1

Please check ✓ all that apply.

When did you last visit the dentist?
_ 3 months or less _6 months _1 year _5 years _I don't remember/other _____

What was the purpose of that visit?
_Cleaning _Exam _Whitening _Crown/Bridge _Root canal _Consult
_Implant _Braces _Extraction _Pain relief _Don't remember

Do you have, or can obtain, a complete set of x-rays or panoramic x-ray taken within the last 15 months?
_Yes _No _Maybe
If **Yes** or **Maybe**, please provide information to help us obtain them: _____

Do any of your teeth hurt?
_Yes _No _Not sure
If Yes or Not sure, please explain _____.

Are any of your teeth or gum areas sensitive or tender? Please check as many as are appropriate.
_Teeth _Gums _Tender _Sensitive

When does this happen?
_Eating _Cold _Hot _Sweets _At night

How often do you experience the sensitivity or pain?
_Often _Frequent _Infrequent _Sporadic

Are there any growths or sores in your mouth? _____ **_Yes _No _Maybe**

Do you have any pain or clicking in your jaw joint? _____ **_Yes _No _Sometimes**

Do you grind or clench your teeth? _____ **_Yes _No _Not sure**

Are any of your teeth moving or becoming loose? _____ **_Yes _No _Not sure**

Do you catch food in or around any of your teeth or gums?_____ **_Yes _No**

Do your gums bleed while brushing your teeth?_____ **_Yes _No**

Do your gums bleed while eating? _____ **_Yes _No**

THE KODISH-PEREZ
DENTAL GROUP

Dental History Page 2

_Orthodontic treatment
If yes, _Braces _Invisalign _Retainer _Other _____

_Oral surgery
If yes, _Extraction _Implant _Biopsy _Other _____

_Teeth whitening
If yes, _In-office _At-home trays _Over -the counter- product _Other

_Periodontal treatment
If yes, _Scaling _Bone/Gum graft _Other _____

_Endodontic treatment
If yes, _Root canal _Pulp cap _Abscess treatment _Apicoectomy

_Implants
If yes, are you: _Satisfied _Dissatisfied _Other _____

_Porcelain Veneers
If yes, are you: _Satisfied _Dissatisfied _Other _____

_Bonding
If yes, are you: _Satisfied _Dissatisfied _Other _____

While having previous dental treatment, have you ever:
_Fainted _An allergic reaction _Abnormal Prolonged bleeding _Other _____

On a scale of 1-10, please rate your smile (1=Cant' stand them; 10=Perfect) # _____

How do you feel about the appearance of your teeth?

_____

_____

If you could change your smile, how would you change it? _____

_____

Do you have any other dental concerns?
_Yes _No _Possibly If yes or possibly, please explain: _____

_____

I fully understand the questions asked on this form. I authorize the release of any information upon the written request of a third party payer or health care practitioner. To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes in my oral health status, I will inform Dr. Perez, Dr. Kodish and their team prior to or at my next appointment.

_____ _____ _____

Patient Signature **Patient Name (Printed)** **Date**