POOJA HEGDE DDS
FAMILY DENTISTRY
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Personal Information

Patient's Name _____ Today's Date _____

Birth Date _____ S.S.# _____-____-_____

Status *(please circle)* Child / Adult Single Married Divorced Widowed Parent's/Spouse's Name _____

Billing Address _____ City/State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail Address *(for appointment reminders)* _____

In case of emergency, who may we contact? Name _____ Phone _____

Whom may we thank for referring you? _____

Employment

Employer _____ Occupation _____

Work Address _____ City/State _____ Zip _____

Work Phone _____ May we call you at work? _____

If so, what is the best time to reach you? _____

Spouse's Employer _____ Work Phone _____

If student, name of school _____

Dental Insurance

Insured's Name _____ Relationship to Patient _____

Insured's Birth Date _____ S.S.# _____-____-_____ Employer _____

Insurance Company _____ Phone No: _____ Claims Address: _____

Secondary Insurance *(if applicable)*

Insured's Name _____ Relationship to Patient _____

Insured's Birth Date _____ S.S.# _____-____-_____ Employer _____

Insurance Company _____ Phone No: _____ Claims Address: _____

I have received copies of the 2004 Dental Materials Fact Sheet and Notice of Privacy Practices as required by law.

____ You may leave telephone messages referring to my dental care

____ You may NOT leave telephone messages referring to my dental care

By signing this, I authorize Dr. Pooja Hegde to release any patient record information needed to process benefit claims and to submit claim forms for services I or my dependents will receive. I also assign directly to Dr. Pooja Hegde all insurance benefits, if any, for services rendered and I agree to be responsible for all charges not paid by my insurance.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x - rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Yes No DK

Are you now under the care of a physician? ☐ ☐ ☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health? ☐ ☐ ☐

Has there been any change in your general health within the past year? ☐ ☐ ☐

If yes, what condition is being treated?

Date of last physical exam:

Yes No DK

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ ☐ ☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ ☐ ☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

(Check DK if you Don't Know the answer to the question)

Yes No DK

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: _____ If yes, have you had any complications?

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date Treatment began: _____

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐

If so, how interested are you in stopping?

Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐

Number of weeks: _____

Taking birth control pills or hormonal replacement? ☐ ☐ ☐

Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:

To all **yes** responses, specify type of reaction.

Yes No DK

Local anesthetics ☐ ☐ ☐

Aspirin ☐ ☐ ☐

Penicillin or other antibiotics ☐ ☐ ☐

Barbiturates, sedatives, or sleeping pills ☐ ☐ ☐

Sulfa drugs ☐ ☐ ☐

Codeine or other narcotics ☐ ☐ ☐

Metals ☐ ☐ ☐

Latex (rubber) ☐ ☐ ☐

Iodine ☐ ☐ ☐

Hay fever/seasonal ☐ ☐ ☐

Animals ☐ ☐ ☐

Food ☐ ☐ ☐

Other ☐ ☐ ☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes No DK

Artificial (prosthetic) heart valve ☐ ☐ ☐

Previous infective endocarditis ☐ ☐ ☐

Damaged valves in transplanted heart ☐ ☐ ☐

Congenital heart disease (CHD)

- Unrepaired, cyanotic CHD ☐ ☐ ☐
- Repaired (completely) in last 6 months ☐ ☐ ☐
- Repaired CHD with residual defects ☐ ☐ ☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes No DK

Cardiovascular disease ☐ ☐ ☐

Angina ☐ ☐ ☐

Arteriosclerosis ☐ ☐ ☐

Congestive heart failure ☐ ☐ ☐

Damaged heart valves ☐ ☐ ☐

Heart attack ☐ ☐ ☐

Heart murmur ☐ ☐ ☐

Low blood pressure ☐ ☐ ☐

High blood pressure ☐ ☐ ☐

Other congenital heart defects ☐ ☐ ☐

Mitral valve prolapse ☐ ☐ ☐

Pacemaker ☐ ☐ ☐

Rheumatic fever ☐ ☐ ☐

Rheumatic heart disease ☐ ☐ ☐

Abnormal bleeding ☐ ☐ ☐

Anemia ☐ ☐ ☐

Blood transfusion ☐ ☐ ☐

If yes, date: _____

Hemophilia ☐ ☐ ☐

AIDS or HIV infection ☐ ☐ ☐

Arthritis ☐ ☐ ☐

Yes No DK

Autoimmune disease ☐ ☐ ☐

Rheumatoid ☐ ☐ ☐

Systemic lupus erythematosus ☐ ☐ ☐

Asthma ☐ ☐ ☐

Bronchitis ☐ ☐ ☐

Emphysema ☐ ☐ ☐

Sinus trouble ☐ ☐ ☐

Tuberculosis ☐ ☐ ☐

Cancer/Chemotherapy/ Radiation Treatment ☐ ☐ ☐

Chest pain upon exertion ☐ ☐ ☐

Chronic pain ☐ ☐ ☐

Diabetes Type I or II ☐ ☐ ☐

Eating disorder ☐ ☐ ☐

Malnutrition ☐ ☐ ☐

Gastrointestinal disease ☐ ☐ ☐

G.E. Reflux/persistent heartburn ☐ ☐ ☐

Ulcers ☐ ☐ ☐

Thyroid problems ☐ ☐ ☐

Stroke ☐ ☐ ☐

Yes No DK

Glaucoma ☐ ☐ ☐

Hepatitus, jaundice or liver disease ☐ ☐ ☐

Epilepsy ☐ ☐ ☐

Fainting spells or seizures ☐ ☐ ☐

Neurological disorders ☐ ☐ ☐

If yes, specify: _____

Sleep disorder ☐ ☐ ☐

Do you snore? ☐ ☐ ☐

Mental health disorders ☐ ☐ ☐

Specify: _____

Recurrent Infections ☐ ☐ ☐

Type of infection: _____

Kidney problems ☐ ☐ ☐

Night sweats ☐ ☐ ☐

Osteoporosis ☐ ☐ ☐

Persistent swollen glands in neck ☐ ☐ ☐

Severe headaches/migraines ☐ ☐ ☐

Severe or rapid weight loss ☐ ☐ ☐

Sexually transmitted disease ☐ ☐ ☐

Excessive urination ☐ ☐ ☐

Has a physician or previous dentist recmmended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐

Please explain:

Dr.Hegde Signature _____

APPOINTMENTS

We plan all appointments carefully in advance and strive hard to stay on schedule and minimize waiting. Please help us by being on time and also calling us at least 48 hours in advance if you need to change an appointment. Unless we are notified that you cannot make your dental appointment, you may be subject to a charge for missed appointments.

I am responsible for this account, including all balances unpaid by my insurance. Accounts in which there has been no monthly payment, and no financial arrangements have been made, may be subject to a 1.5% monthly service charge.

Patient's Signature _____ Date _____

Patient's Name _____