DR. YELITZA R. ARARAT, D.M.D

B.Sc. D.D.S CERT. PROSTHO. PROSTHODONTIST

Your cooperation in completing this questionnaire is essential in establishing a basis for comprehensive dental treatment. All information is confidential.

Day / Mth / Year

TODAY'S DATE: ______ / ______ / ______

GENERAL INFORMATION

FULL NAME: ____ Mr. Mrs. Ms. Miss. Dr.
ADDRESS: ____
CITY: ______________________ **POSTAL CODE:** ______________________
HOME PHONE: (_______) __________-___________ **BUSINESS PHONE**: (_______) ________-__________ ext. _____________
E-MAIL ADDRESS: ____
OCCUPATION: ______________________ **EMPLOYER**: ______________________
DATE OF BIRTH: Day: _______ / Month: ________ / Year: ____________
DENTAL INSURANCE *(COMPANY)*: ______________________
POLICY/ GROUP NUMBER: ______________________ **GROUP I.D**: ______________________
SECONDARY INSURANCE HOLDERS NAME: ______________________ **D.O.B**______________________
SECONDARY DENTAL INSURANCE: POLICY NUMBER: ______________________ **GROUP I.D**: ______________________
SECONDARY DENTAL INSURANCE *(COMPANY)*: ______________________
FAMILY PHYSICIAN: ______________________ **ADDRESS**: ______________________
PHONE: ______________________ **DATE OF LAST MEDICAL EXAM**: ______________________
EMERGENCY CONTACT: ______________________ **PHONE: ______________________**

MEDICAL HISTORY

1. ALL MEDICATIONS currently taking? *(Please include dosages, if possible)*
____
____

2. Any adverse reaction to MEDICATIONS? *(Such as PENICILLIN, SULPHA DRUGS, ASPRIN, CODEINE, LOCAL ANESTHETICS,…)*
____
____
____

3. Recent HOSPITALIZATION and/or SERIOUS ILLNESS? ______________________

4. Do you have any allergies Conditions*? (Such as ASTHMA, HAY FEVER, FOOD ALLERGIES, METAL OR LATEX ALLERGIES …)*
____

5. Drug or Alcohol dependency? ______________________
6. Do you smoke? YES ______ NO ______ if so, how often? ______________________
7. Please indicate which of the following you presently have or ever had:

			HEAD / NECK INJURY	*YES*	*NO*
A.I.D.S / H.I.V	*YES*	*NO*	**HEART DISEASE**	*YES*	*NO*
ANEMIA	*YES*	*NO*	**HEART PACEMAKER**	*YES*	*NO*
ARTHRITIS	*YES*	*NO*	**HEART VALVE MURMUR**	*YES*	*NO*
ATIFICIAL HEART VALVE	*YES*	*NO*	**HEPATITIS**	*YES*	*NO*
ARTIFICIAL JOINTS	*YES*	*NO*	**HIGH/LOW BLOOD PRESSURE**	*YES*	*NO*
ASTHMA	*YES*	*NO*	**HORMONE DISORDER**	*YES*	*NO*
BLEEDING DISORDERS	*YES*	*NO*	**LIVER DISEASE**	*YES*	*NO*
CANCER/ CHEMOTHERAPY	*YES*	*NO*	**OSTEOPOROSIS**	*YES*	*NO*
DIABETES	*YES*	*NO*	**PHYCHIATRIC DISORDER**	*YES*	*NO*
			RHEUMATIC FEVER	*YES*	*NO*

Additional Comments: ______________________
8. WOMEN ONLY: Are you PREGNANT or suspect you may be: _____ YES _____ NO
Are you taking BIRTH CONTROL PILLS: _____ YES _____NO
Are you taking supplementary hormones, please indicate: ______________________
9. Any other disease, condition or problem not listed: ______________________

DENTAL HISTORY

Please indicate WHO referred you to this practice: ____
Do you have a GENERAL DENTIST that you see on a regular basis: ____

1. DESCRIBE in your own words your MAIN CONCERN for improving your dental health?
(I.e. improve smile, better chewing ability, whiter teeth…)
____
____
____
____

2. Do you have any DISCOMFORT relating to your teeth? Yes _____ or No _____ if yes, explain: __________________________

3. Do you have any difficulty CHEWING? YES ____ NO ____ If yes, explain: ____

4. Are there any sore spots or growths in your mouth or tongue? YES ____ or NO ____ If yes, explain: _____________________
5. Have you ever experienced any of the following JAW problems:
   Popping/Clicking in your jaw joints? YES _____ NO _____
   Pain in your jaw joints, ears or side of the face? YES ____ NO ____ If yes, explain: ______________________________
   Difficulty in opening and closing? YES _____ NO _____ If yes, explain: ____
   Clenching or grinding your teeth while awake or during sleep? YES ____ NO____ If yes, explain: __________________
6. If you are wearing partial or complete DENTURES:
   WHEN were they made? Upper: ___________________________ Lower: _________________________________
   Do you have any DIFFICULTIES with your dentures? YES ____ NO _____ if yes, explain: ________________________
   Do you wear the dentures at NIGHT? Yes _____ No ______
7. Have you ever received Dental or Jaw Implants? YES _____ NO _____ if yes, when: __________________________________
8. Are you satisfied with the appearance of your teeth or smile? YES _____ NO ____
   Are you pleased with the COLOUR of your teeth? YES ____ NO ____
9. ADDITIONAL COMMENTS CONCERNING YOUR DENTAL HISTORY: ____
____
____
____
____
____
____

THANK YOU for the completion of this form. In addition, PLEASE read the following:

I, the undersigned, certify that I have provided an accurate and complete personal medical-dental history and knowingly have not omitted any information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental therapy I also understand that consultation with my medical doctor or other dental practitioners may be required and I consent to their approach for consultation. I will also undertake responsibility for payment of all the dental services that is performed during each of their appointments. In addition, I consent to the utilization of any extra-oral or intra-oral photographs for educational purposes.

SIGNATURE: ____ DATE: ____

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