Welcome to Dr. Tawa's Office

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name _____ MI _____ Last Name _____ Nickname _____

☐ Male ☐ Female Birth Date ____/____/_____ Soc Sec # _____ Patient a Minor? _____

Street _____ City _____ State _____ Zip _____

Home Tel #_____ Cell Phone # _____ Work Phone # _____

EMAIL _____ Appointment Contact Method: ☐ Email ☐ Text ☐ Phone

Status ☐ Single ☐ Married ☐ Divorced ☐ Widow Do you have children? ☐ Yes ☐ No How many? _____

Referred By _____ Occupation _____

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Parent _____ ☐ Other _____

Subscriber's Name _____ Soc Sec # _____ Birthdate _____

Address _____ Phone # _____ Employer _____

Note: The patient is responsible for any amount not covered by insurance, and any costs incurred in collection of a delinquent account. There will be an annual interest rate charge of 10% for any account over 90 days.

INSURANCE INFORMATION

Primary Dental Insurance	Secondary Dental Insurance
Insurance Co Name: _____	Insurance Co Name: _____
Employee Name: _____	Employee Name: _____
Employer: _____	Employer: _____
Employee ID #: _____	Employee ID #: _____
Group #: _____ Local Union #: _____	Group #: _____ Local Union #: _____

In Event of Emergency:

Contact: _____ Relation: _____ Home phone: _____ Cell Phone: _____

Name Medical Doctor: _____

Dr's Phone #: _____ Date last physical exam: _____

Health History

Reason for today's office visit? _____ In Pain? _____ Women: Are you pregnant? ☐ yes ☐ no

Have you had any serious illnesses, operations, or been hospitalized in the past 5 years? If yes, describe:

_____

Have a prosthetic joint / implant, metal rods, or pins? If so, describe _____

Medical History

	Yes	No	Notes
Are you in good health?			
Presently under a physician care?			
HIV+ / AIDS / ARC?			
Cardiovascular disease? (heart attack, stroke, mitral valve prolapse, congenital defect, etc.)			
Pacemaker?			
Blood disorder, bleeding tendency, or bruise easily? Blood Transfusion?			
Anemic?			
Diabetic?			
High blood Pressure? Low blood pressure? circle			
Cancer?			
Radiation Treatment?			
Epilepsy? Fainting spells? Seizures?			
Asthma, emphysema or any lung disorder?			
Liver disease? Hepatitis? Jaundice?			
Arthritis?			
Tuberculosis?			
Psychiatric problems? Dementia?			
Kidney Problems?			
Thyroid disease?			
Take/taken Bisphosphate (such as Fosamax, Actonel, Boniva, etc) for Osteoporosis?			
Take/taken Phen-fen, Redux, or Diet Pills?			
Herpes? Fever Blisters?			
Rheumatic or Scarlet Fever?			
Neck or back problems?			
Smoke or use tobacco?			

Dental History

Please indicate any of the following problems:

☐ Discomfort, clicking or popping in jaw / TMJ
☐ Red, swollen or bleeding gums
☐ Sensitive tooth, teeth, gums
☐ Teeth grinding, clench teeth
☐ Stained teeth
☐ Bad breath
☐ Periodontal disease
☐ Other _____

Has your doctor said you need to pre-medicate before dental work? ☐ yes ☐ no

Medication: _____

Trouble with previous dental work? ☐ yes ☐ no

Times a day you brush? _____
Times a week you floss? _____
Ever had gum treatment? _____

Are you happy with the way your smile looks?
☐ yes ☐ no If no, what would you change?

_____

Medications

List medications, drugs, injections below (or write "NONE"):

_____

Allergies - Are you allergic to, or had any reaction to . . .

	Yes	No			Yes	No
Local anesthetic				Aspirin		
Penicillin / Amoxicillin / Erythromycin				Latex		
Other Antibiotics (List)				Other (ex. Codeine, Jewelry, Metals) (List)		

This information is true & correct to the best of my knowledge. Signature:_____ Date: _____