LOVEABLE SMILES
Lawrence J. Korenman, D.D.S.
Office: (972) 231-0585
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WELCOME TO OUR OFFICE

Today's Date: ____________________________

Patient Name ____________________________________ Date of Birth________ Age _____ Male / Female

Address____ City, State ______________________ Zip _______

Home Phone _________________ Work Phone ___________________ Cell Phone _____________________

E-Mail Address _______________________ Social Security No. ___________ Drivers License No. _________

Employer ________________________ Address ____

City _____________________________ State _______ Zip ______ Full time student, Where? _____________

Marital Status: S M D W Spouse's Name _______________________ Date of Birth __________________

Responsible Party (if different than patient) ____

Address ____ City, State ______________________ Zip ________

Home Phone _________________ Work Phone __________________ Cell Phone _____________________

Date of Birth ______________________ Social Security No. ______________ Drivers License No. _________

Insurance Company Name ______________________________ ID or Social Security No. ________________

Employer Name ____ Group No. ___________________________

Employee Name ____ Date of Birth _________________________

Person to contact in case of emergency ____

Home Phone ________________________ Work Phone __________________ Cell Phone _______________

Whom may we thank for referring you to our office? ____

DENTAL HEALTH HISTORY

To provide you with the best possible care, please complete the dental and medical history form. All information is completely confidential.

What is the reason for your visit today? ____

Date of Last Dental Visit ___________ **Date of Last Cleaning** ___________ **Date of Last Full Mouth X-Rays**_______

What was done at your last dental visit? ____

Previous Dentist's Name __________________________________ Telephone No. ___________________________

Address ____ City, State ______________________ Zip _________

** HIPPA regulations requires you (the patient) to contact your previous Dentist to release your x-rays.**

How often do you have dental examinations? _____________ How often do you brush your teeth? ______________________

How often do you floss?_________________ What other dental aids do you use? (Sonicare,toothpick,etc.) _____________________

Do you have any dental concerns now? _____ **Yes** _____ **No** If yes, please describe: _____________________________

Do you feel nervous about treatment? ____ Yes ____ No If yes, please describe: ____

Have you had an upsetting dental experience? ____ Yes ____ No If yes, please describe: ______________________________

How would you improve your smile if you could? ____

Are any of your teeth sensitive to: (please circle)

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No

Do you:

Notice any mouth odors or bad tastes?	Yes	No
Frequently get cold sores, blisters or any oral lesions?	Yes	No

Do your gums bleed or hurt?	Yes	No	**Do You:**		
Any gum disease in family members?	Yes	No	Clench or grind your teeth?	Yes	No
Tooth Loss?	Yes	No	Bite your lips or cheeks regularly?	Yes	No
Have you noticed any loose teeth?	Yes	No	Hold foreign objects with your teeth?	Yes	No
Have you noticed a change in your bite?	Yes	No			
Does food get caught in your teeth?	Yes	No	Breath through your mouth?	Yes	No
If yes, where? ____________________			Have tired jaws, especially in the morning?	Yes	No
			Smoke or chew tobacco?	Yes	No
Have you ever had?			**Have you noticed or experienced:**		
Any undesirable effect from local anesthetic?	Yes	No	Clicking or popping of your jaw?	Yes	No
Any undesirable effect from nitrous oxide?	Yes	No	Pain? (joint, ear, side of face)	Yes	No
Orthodontic treatment?	Yes	No	Difficulty in opening or closing mouth?	Yes	No
Oral Surgery?	Yes	No	Difficulty chewing on either side?	Yes	No
Periodontal Treatment?	Yes	No	Headaches or shoulder aches?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No	Sore muscles?	Yes	No
A bite plate or mouth guard?	Yes	No	Are you satisfied with your teeth's appearance?	Yes	No
A serious injury to the mouth or head?	Yes	No	Is keeping all of your teeth very important?	Yes	No
If so please describe, including cause: ___________					

MEDICAL HISTORY

Have your EVER had any of the following:

Abnormal Blood Pressure	Yes	No	Heart Valve Replacement (when)	Yes	No
Angina or Chest Pain	Yes	No	Heart Disease	Yes	No
Anemia	Yes	No	Hyperthyroid/Hypothyroid(Thyroid Disease)	Yes	No
Arthritis or Rheumatism	Yes	No	Jaundice/ Liver Disease	Yes	No
Asthma (Hay Fever)	Yes	No	Joint Replacement (when) ____________	Yes	No
Blood Disorders: Type ______________	Yes	No	(which joint) _________________		
Bruise Easily	Yes	No	Kidney/ Bladder/ Liver Disease	Yes	No
Contact Lenses	Yes	No	Hepatitis Type A_ B_ C_	Yes	No
Cancer or Tumor	Yes	No	Mitral Valve Prolapse	Yes	No
Diagnosis ________________	Yes	No	Regurgitation	Yes	No
Prognosis ________________	Yes	No	Positive HIV Test	Yes	No
Chemo/Radiation	Yes	No	Rheumatic Fever	Yes	No
Diabetes	Yes	No	Aids	Yes	No
Digestive Problems	Yes	No	Prolonged Bleeding	Yes	No
Emphysema	Yes	No	Psychiatric Care	Yes	No
Epilepsy	Yes	No	Prosthetic Devices _______________	Yes	No
Fainting	Yes	No			
Glaucoma (Narrow/Wide Angle)	Yes	No	Recent Weight Loss	Yes	No
Hearing Disorders	Yes	No	Sinus Problems	Yes	No
Chest Pain	Yes	No	Shortness of Breath	Yes	No
Heart Attack (when) _______________	Yes	No	Stroke/Seizures (when) ___________	Yes	No
Heart Surgery (when) ______________	Yes	No	Tuberculosis	Yes	No
Heart Murmur (when) _______________	Yes	No	Venereal Disease	Yes	No
			Ulcers	Yes	No

Have you been hospitalized in the last three years? Yes No Why? ____

Please list any surgeries and date of surgeries:

____

Do you have an allergic reaction to Penicillin, or any other drugs? (what) __________________________________	Yes	No
Do you have an allergy to foods, metals, Mercury or other? (what) ____	Yes	No
Have you ever or are you taking: Cortisone, Steroids, Blood Thinner, Tranquilizers, or Fosamax?	Yes	No
Are you pregnant? Yes No Due Date _______________ Nursing	Yes	No
Have you been advised to NOT take any other particular medication? (what and why) _______________________	Yes	No
Have you ever taken any weight loss products, Phen-Fen, Redux or other? (what) ___________________________	Yes	No

Are you presently:

Having any medical problems? If yes, explain ____ Yes No

Being treated by a physician? Yes No For what condition? ____

When was your last visit to a medical Doctor? ____

Planning or receiving any medical treatment in the near future? If yes, please explain ________________________________

Taking any medication or drugs? Yes No If yes, please list:

____

Name of Family Physician: ________________________________ City _____________________ Phone No. ____________________

Doctors Signature: ____ Today's Date __________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/ Guardian Signature: ____ Today's Date ____________________

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