Alpha Dental
Ruslan Korobeinik, DDS

Welcome to our practice

Please, take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

PATIENT NAME_____

TODAY'S DATE_____ **BIRTH DATE** _____**PATIENT SS #** _____

ADDRESS _____ **apt.** _____

CITY_____**ZIP CODE**_____

☐ **MALE** ☐ **FEMALE** ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **SEPARATED**

Home phone _____**Work phone** _____

Cell _____ Employer _____

Occupation _____ E- mail _____

MEDICAL INFORMATION

PHYSICIAN NAME AND PHONE NUMBER _____

IN CASE OF EMERGENCY CONTACT:

NAME _____ **RELATIONSHIP** _____

EMERGENCY PHONE _____EMERGENCY WORK PHONE _____

WHO MAY WE THANK FOR REFERRING YOU TO US?

WHY HAVE YOU COME TO THE DENTIST TODAY?

_____

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENTS? **YES** **NO**

PRIMARY DENTAL INSURANCE CARRIER _____

INDIVIDUAL RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP TO PATIENT _____ **BIRTH DATE** _____**SS#** _____

RESPONSIBLE PARTY EMPLOYED BY _____ OCCUPATION _____

HOME PHONE _____**ADDRESS** _____

CITY _____ **ZIP CODE**_____

SECONDARY DENTAL INSURANCE CARRIER _____

INDIVIDUAL RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP TO PATIENT _____ **BIRTH DATE** _____**SS#** _____

RESPONSIBLE PARTY EMPLOYED BY _____ OCCUPATION _____

HOME PHONE _____**ADDRESS** _____

CITY _____ ZIP CODE_____

DENTAL HISTORY

HAVE YOU EVER EXPERIENCED PAIN/ DISCOMFORT IN YOUR JAW JOINT (TMJ/ TMJD)?		YES	NO
ARE YOU IN PAIN NOW?		YES	NO
YOUR CURRENT DENTAL HEALTH IS:	GOOD	FAIR	POOR
DO YOU LIKE YOUR SMILE?		YES	NO
DO YOUR GUMS BLEED?		YES	NO
HAVE YOU EVER HAD PERIODONTAL DISEASE?		YES	NO

HOW MANY TIMES A DAY DO YOU FLOSS? _____ DO YOU BRUSH? _____

TYPES OF TOOTHBRUSH BRISTLES?	**HARD**	**MEDIUM**	**SOFT**

MEDICAL HISTORY

YOUR CURRENT PHYSICAL HEALTH IS: GOOD FAIR POOR

ARE YOU TAKING ANY PRESCRIPTIONS/ OVER-THE-COUNTER OR SUPPLEMENT DRUG? YES NO

PLEASE LIST EACH ONE:

_____

DO YOU SMOKE OR USE TOBACCO IN ANY FORM? YES NO

FOR WOMEN: ARE YOU TAKING BIRTH CONTROL PILLS? YES NO

ARE YOU PREGNANT? YES NO ARE YOU NURSING? YES NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASE OR MEDICAL PROBLEMS? (PLEASE CIRCLE OPTION THAT APPLIES)

Y	N	ANEMIA/RADIATION TREATMENT	Y	N	HEMOPHILIA/ABNORMAL BLEEDING
Y	N	ARTIFICIAL JOINTS/VALVES	Y	N	HEPATITIS
Y	N	ARTHRITIS	Y	N	HIGH/LOW BLOOD PRESSURE
Y	N	ASTHMA	Y	N	BLOOD TRANSFUSION
Y	N	CANCER/CHEMOTHERAPY	Y	N	HIV+/AIDS
Y	N	CONGENITAL HEART DEFECT	Y	N	HOSPITALIZED FOR ANY REASON
Y	N	DIABETES TYPE 1 TYPE 2	Y	N	KIDNEY PROBLEMS
Y	N	DIFFICULT BREATHING	Y	N	MITRAL VALVE PROLAPSE
Y	N	DRUG/ALCOHOL ABUSE	Y	N	PSYCHIATRIC PROBLEMS
Y	N	EMPHYSEMA/GLAUCOMA	Y	N	RHEUMATIC/ SCARLET FEVER
Y	N	FEVER BLISTERS/ HERPES	Y	N	SEVERE/ FREQUENT HEADACHES
Y	N	THYROID CONDITIONS	Y	N	EPILEPSY/ SEIZURES/ FAINTING SPELLS
Y	N	HEART ATTACK/ STROKE	Y	N	SICKLE CELL ANEMIA
Y	N	HEART MURMUR	Y	N	TUBERCULOSIS (TB)
Y	N	HEART SURGERY/ PACEMAKER	Y	N	SINUS PROBLEMS
Y	N	ULCERS/ COLITIS	Y	N	VENERAL DISEASE

PLEASE LIST ANY SERIOUS MEDICAL CONDITION (S) THAT YOU HAVE EVER HAD:

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

___ASPIRIN ___ERYTHROMYCIN ___PENICILLIN ___CODEINE
___TETRACYCLINE ___DENTAL ANESTHESIA ___LATEX OTHER_____

AUTHORIZATION

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS**. I AUTHORIZE THIS DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES THAT I NEED DURING DIAGNOSIS AND TREATMENT WITH MY INFORMED CONSENT.**

I CERTIFY THAT I AM COVERED BY _____ INSURANCE CO. AND I ASSIGN DIRECTLY TO DR. KOROBEINIK ALL INSURANCE BENEFITS, OTHERWISE PAYABLE TO ME.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AND ALSO RESPONSIBLE FOR PAYING ANY CO-PAYMENTS AND DEDUCTIBLES THAT MY INSURANCE DOES NOT COVER. I HEREBY AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS, WHETHER MANUAL OR ELECTRONIC.

Patient or legal guardian signature_____ DATE_____Recall Review

1. Patient signature_____ Date_____
2. Patient signature_____ Date _____
3. Patient signature_____ Date_____