It is our pleasure to welcome you to Dr. Avetoom's dental office. Your dental heath and well being are our primary concern. Please take a few moments to fill out this questionaire as accurately as possible.

Referred by ______________________

Patient's Name ______________________ Sex ☐ M ☐ F Age ________ Birthdate ______________

Home Address ______________________ Social Security # ______________

City ______________ State ________ Zip Code ________ Drivers License ______________

Home # ( ) ______________ Work # ( ) ______________ Cell # ( ) ______________

Email: ______________________ Best way to contact: ☐ Home ☐ Cell ☐ Work ☐ Email

Patient's Employment or School (Father's / Mother's if a minor) ______________ Occupation ______________

Employer's Address ______________ City ______________ State ________ Zip Code ________

Dental Insurance ☐ Yes ☐ No Subscriber/Primary Insured: ______________ Relationship ________

Is Patient covered by additional insurance? ☐ Yes ☐ No Primary SSN # ______________ Birthdate ________

Ins. Co. ______________________ Group #: ______________

Spouse's Name (Father's / Mother's if a minor) ______________ Birthdate ______________ SSN # ______________

Home # ( ) ______________ Cell # ( ) ______________

Email: ______________________ Best way to contact: ☐ Home ☐ Cell ☐ Work ☐ Email

Spouse's Employment ______________________

Employer's Address ______________________

City ______________ State ________ Zip Code ________

Occupation ______________________ Work # ( ) ______________

In Case Of Emergency Contact ______________________ Telephone ( ) ______________

Address ______________ City ______________ Zip Code ________

Person Responsible For Payment ______________________

Circle Yes or No

1. Are you having pain or discomfort at this time? .... YES NO
2. Do you feel very nervous about having dentistry treatment? .... YES NO
3. Have you ever had a bad experience in the dentistry office? .... YES NO
4. Have you been a patient in the hospital during the past two years? .... YES NO
5. Have you been under the care of a medical doctor during the past two years? ... YES NO
6. Have you taken any Medicine or drugs during the past two years? .... YES NO
7. Have you ever had any excessive bleeding requiring special treatment? .... YES NO
8. Do you use tobacco? .... YES NO
9. When you walk up stairs or take a walk do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? .... YES NO
10. Do you use more than 2 pillows to sleep? .... YES NO
11. Have you lost or gained more than 10 pounds in the past year? .... YES NO
12. Has your medical doctor ever said you have a cancer or tumor? .... YES NO
13. Do you have any disease, condition, or problem not listed? .... YES NO
14. Last Dental Appointment ______________ Last X rays ________

MEDICATIONS	ALLERGIES	
List any medications you are currently taking and the correlating diagnosis:	☐ Aspirin	☐ Local Anesthetic
______________________	☐ Barbiturates (Sleeping pills)	☐ Penicillin
______________________	☐ Codeine	☐ Sulfa
Pharmacy Name ______________	☐ Lodine	☐ Other ______________
Phone ( ) ______________	☐ Latex	______________

We kindly request a 24 hour cancellation notice or our standard fee may be assessed to your account.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the doctor of dentistry at the next appointment without fail.

Permission is hereby granted to the dentists and hygienists to administer local anesthesia or sedation (with my consent) and render any dental services as deemed necessary for me.

Note: Co payment & deductibles are due at the time of the appointment. We will bill your insurance as a courtesy to you. I accept full legal responsibility for payment of all dental services.

______________________ ______________

Signed Date