Robert H Klein, DDS, PC
Dr Alan A DeRosa, DDS

(Please Circle)
Mr., Mrs., Ms., Miss
Patient First Name_____ Middle Initial _____ Last Name _____

Home Phone Number _____ Date of Birth _____ SSN # _____

Cell Phone Number _____ Email Address _____

Address _____ City _____ State _____ Zip _____

Employer (Company Name) _____ Work No. _____

Dental Insurance _____ Policy Holder's Name _____

Policy Holder Date of Birth _____ Policy Holder SS # _____

Physician _____ Physician Phone _____

Emergency Contact _____ Phone No. _____

Have you been hospitalized within the past 2 years? Yes _____ No _____

If yes, please explain: _____

Have you had any joint/hip replacement?	Yes _____	No _____
If yes, have you been told to pre-med before any dental treatment?	Yes _____	No _____
Have you ever had any reaction to dental anesthetic/Epinephrine?	Yes _____	No _____
Have you ever experienced abnormal bleeding ?	Yes _____	No _____
Do you take aspirin on a daily basis?	Yes _____	No _____
Do you have any sensitivity to Latex?	Yes _____	No _____

FOR WOMEN ONLY: Could you be pregnant now? Yes _____ No _____

Please **CIRCLE** any of the following which you presently have or have had in the past:

Mitral Valve Prolapse	Asthma	Cancer	Psychiatric Problems
Rheumatic Fever	Tuberculosis	Chemo/Radiation	Sexually Transmitted Disease
Pacemaker	Aids or HIV	Chronic Cold Sores	Sinus
High Blood Pressure	Hepatitis	Arthritis	Heart Murmur
Epilepsy	Stroke	Panic Attacks	
Hemophilia	Diabetes	Neurological Problems	

Other Not Listed _____

Please list ALL medications that you are currently taking _____

_____

Have you ever had a reaction to any medication? _____

If yes, which ones? _____

What type of reaction? _____

WARNING! Failure to disclose any past/present medical condition may adversely affect your care.

SIGNATURE _____ DATE _____

(Parent or Guardian if patient is minor)

REVIEWED BY, WITH PATIENT _____ DATE _____

Dental Info

1) When was your last dental visit? _____
2) What was done at last visit? _____
3) If there was a simple inexpensive way to whiten your teeth would you be interested? Y____ N_____
4) Do you have pain in your jaw joint near your ears? Y____ N_____
5) Is there anything you would like to change about your smile?
_____
6) Any difficult extractions or prolonged bleeding following extraction in the past? Y_____ N_____
7) Do your gums bleed? Y_____ N_____
8) Are you interested in avoiding or treating bad breath? Y_____ N_____
9) Do you habitually grind your teeth at night or during the day? Y_____ N_____
10) If there was a way to help you or your spouse with a snoring problem by use of a oral appliance would you be interested? Y_____ N_____
11) What have you liked most about any dental office you've been to before?
_____
_____
12) What have you liked least about any dental office you've been to before?
_____
_____
13) What are you expecting to have done today?_____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this info will be held in the strictest confidence with the office staff. It is my responsibility to inform this office of any changes in my medical status. I give permission for this office to confirm my appointments at home or work by leaving a message with a person or on a machine.

THIS OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

Signature_____ Date _____

Notes_____
_____
_____
_____
_____