Tarkis Barsamian DDS
161 W. Sunset Dr Ste 202
Waukesha, WI 53189
Ph 262-544-1100

DENTISTRY BY
TARK BARSAMIAN D.D.S. & ASSOCIATES

PATIENT DENTAL HISTORY

PATIENT'S NAME_____**DATE OF BIRTH**_____

REASON FOR THIS VISIT_____

WHEN WAS YOUR LAST DENTAL VISIT_____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN_____

PREVIOUS DENTIST (NAME AND LOCATION)_____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL X-RAYS TAKEN, WHEN AND WHERE_____

HOW OFTEN DO YOU BRUSH YOUR TEETH_____**HOW OFTEN DO YOU FLOSS**_____

IS YOUR DRINKING WATER FLUORIDATED_____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING.....	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS.....	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS.....	☐	☐
DO YOU FEEL PAIN IN ANY OF YOUR TEETH.....	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.....	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING.....	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE).....	☐	☐
DIFFICULTY IN OPENING OR CLOSING.....	☐	☐
DIFFICULTY IN CHEWING.....	☐	☐
DO YOU HAVE FREQUENT HEADACHES.....	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH.....	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH.....	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH.....	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).....	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE.....	☐	☐
HAVE YOU HAD ANY DIFFICULT EXTRACTIONS IN THE PAST.....	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	☐	☐
DO YOU WEAR DENTURES OR PARTIALS.....	☐	☐
IF YES, DATE OF PLACEMENT_____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS.....	☐	☐
ARE YOU HAPPY WITH YOUR SMILE.....	☐	☐

IF YOU COULD CHANGE <u>ANYTHING</u> ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?_____
fghj

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X_____**DATE**_____

SIGNATURE OF PATIENT, OR PARENT IF MINOR

DOCTOR'S COMMENTS

_____**SIGNATURE**_____**DATE**_____

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PATIENT MEDICAL HISTORY

Date_____

PATIENT'S NAME_____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS. THERE ARE TWO SIDES TO THIS FORM, PLEASE COMPLETE BOTH SIDES.

	YES	NO
1 ARE YOU IN GOOD HEALTH?.....	☐	☐
2 HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?.....	☐	☐
3 DATE OF YOUR LAST PHYSICAL EXAM:_____		
4 PHYSICIAN'S NAME_____		
ADDRESS_____		
PHONE NO._____		
5 ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?.....	☐	☐
6 HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?.....	☐	☐
PLEASE EXPLAIN_____		
_____		
7 ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE?.....	☐	☐
IF YES, WHAT MEDICINE(S) ARE YOU TAKING?_____		
_____		
8 HAVE YOU HAD ANY ABNORMAL BLEEDING?.....	☐	☐

	YES	NO
9 DO YOU BRUISE EASILY?.....	☐	☐
10 HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?.....	☐	☐
11 HAVE YOU HAD A RECENT WEIGHT LOSS?.....	☐	☐
12 HAVE YOU EVER TAKEN FEN-PHEN OR REDUX?.	☐	☐
13 DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES?.....	☐	☐
14 ARE YOU WEARING CONTACT LENSES?.....	☐	☐
15 DO YOU USE TOBACCO?.....	☐	☐
16 DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?.....	☐	☐

WOMEN ONLY

	YES	NO
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?.....	☐	☐
ARE YOU NURSING?.....	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS?.....	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE?	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS?	☐	☐
SULFA DRUGS?	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS?	☐	☐
ASPIRIN?	☐	☐
IODINE?	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)?	☐	☐
LATEX/RUBBER?	☐	☐
OTHER (PLEASE LIST)_____	☐	☐

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO
RHEUMATIC FEVER?	☐	☐
SCARLET FEVER?	☐	☐
HEART DEFECT OR HEART MURMUR? (PLEASE CIRCLE).	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA?	☐	☐
CHEST PAIN?	☐	☐
SHORTNESS OF BREATH?	☐	☐
PACEMAKER?	☐	☐
HEART SURGERY?	☐	☐
HIGH/LOW BLOOD PRESSURE? (PLEASE CIRCLE)	☐	☐
CONGENITAL HEART PROBLEM?	☐	☐
SWELLING OF FEET, ANKLES, HANDS?	☐	☐
HEPATITIS, JAUNDICE, LIVER DISEASE?(PLEASE CIRCLE)	☐	☐
STROKE?	☐	☐
SINUS TROUBLE?	☐	☐
LUNG OR BREATHING PROBLEMS?	☐	☐
ASTHMA OR HAY FEVER?...(PLEASE CIRCLE)	☐	☐
DEMENTIA, ALZHEIMER'S, MEMORY LOSS?(PLEASE CIRCLE)	☐	☐

	YES	NO
HIVES OR SKIN RASH?	☐	☐
FAINTING OR DIZZY SPELLS?	☐	☐
DIABETES?	☐	☐
AIDS OR HIV INFECTION?	☐	☐
THYROID PROBLEMS?	☐	☐
ALLERGIES?	☐	☐
ARTHRITIS OR RHEUMATISM?	☐	☐
JOINT REPLACEMENT OR IMPLANT?	☐	☐
STOMACH ULCER?	☐	☐
KIDNEY TROUBLE?	☐	☐
TUBERCULOSIS?	☐	☐
PERSISTENT COUGH?	☐	☐
COUGH THAT PRODUCES BLOOD?	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)?	☐	☐
SEXUALLY TRANSMITTED DISEASE?	☐	☐
EPILEPSY OR SEIZURES?	☐	☐
ANEMIA?	☐	☐
GLAUCOMA?	☐	☐
NERVOUSNESS?	☐	☐
TONSILLITIS?	☐	☐
TUMORS?	☐	☐
MENTAL HEALTH CARE?	☐	☐
BACK PROBLEMS?	☐	☐
CHEMICAL DEPENDENCY?	☐	☐
MITRAL VALVE PROLAPSE?	☐	☐
CORTISONE TREATMENT?	☐	☐
COLD SORES/FEVER BLISTERS?	☐	☐
HYPOGLYCEMIA?	☐	☐
EATING DISORDERS?	☐	☐

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PATIENT REGISTRATION

WELCOME! Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be happy to assist you. We look forward to working with you in maintaining your dental health. Thank you.

PATIENT INFORMATION (CONFIDENTIAL)

Name:_____ Date_____ ☐ Male ☐ Female

Address_____City_____State_____Zip_____

Social Security #_____Birthdate_____Home Phone_____

Cell Phone_____ ***Email Address_____

Please Circle One: Minor Single Married Divorced Widowed Separated

Patient or Parent's Employer_____Work Phone_____

May we call you at work? Yes No Business Address_____City_____

Spouse or Parent's Name_____Employer_____Work Phone_____

Person to Contact in Case of Emergency_____Phone_____

HOW DID YOU HEAR ABOUT US?

Person Who Referred You:_____

Or did you find us through: ☐ ATT Phone Book ☐ The Yellow Book ☐ Sign in Front ☐ yellowpages.com
☐ zoomnow.com ☐ suddenvalues.com ☐ Delta Provider Directory ☐ Local Internet Search

RESPONSIBLE PARTY

If Not Same as Above, Please Fill in Below

Name of Person Responsible for this Account_____ Relationship To Patient_____

Address_____Home Phone_____

Driver's License_____Birthdate_____Soc. Sec.#_____

Employer_____Work Phone_____

Is This Person Currently a Patient In Our Office? ☐ Yes ☐ No

I certify that the above information is still current as of:

Date: _____
Date: _____
Date: _____
Date: _____
Date: _____
Date: _____
Date: _____
Date: _____
Date: _____

Please list any changes below:

New address:_____
New Phone #_____

New address:_____
New Phone #_____

New address:_____
New Phone #_____

New address:_____
New Phone #_____

New address:_____
New Phone #_____

X_____
Signature of Patient or Parent if a minor