Patient # ______________

Welcome

Peter D. Kiryakos, D.D.S

Patient Information:

Today's Date: __________________

Full Name: ____ Name you go by: _________________________

Address: ____City: _______________ State: ____ Zip:_____

Social Security #: ______-_____-_______ Whom may we thank for referring you? _______________________

Sex: (M (F Age: _________ Birthdate: _______________ (Single (Married (Divorced (Widowed

Email: ____________________________ Home Phone (____) _____-_________ Cell (____) _____-________

Occupation: _______________________ Employer: __________________ Work Phone (____) ____-_______

*If student, name of school/college: ___________________ City: _________State: ______ (Full time(Part time

Spouse's Name: ______________________ Birthdate: ____________________ Cell (____)_______-________

Occupation: _______________________ Employer: __________________ Work Phone (____) ____-_______

Children – Names & Ages: ① ___________________________ ② ____________________________

③ ___________________ ④ ___________________________ ⑤ ____________________________

Best Time and Place to reach you: ____

Person to contact in case of Emergency: __________________________ Phone (_____) _____-___________

Primary Insurance Information

Person Responsible for this account: ____

Relation to Patient: ________________ Birthdate: ______/_______/________SS# _____--______-________

Insurance Company: ______________________Group #: ________________ ID# ____________________

Secondary Insurance Information

Is Patient covered by additional insurance: Yes (No (….If yes, provide following information:

Relation to Patient: ________________ Birthdate: ______/_______/________SS# _____--______-________

Insurance Company: ______________________Group #: ________________ ID# ____________________

Financial Agreement

For your convenience, we offer the following methods of payment. Please check the option which you prefer: (Cash (Personal Check Credit Card: (Visa (MasterCard

Payment is due in full at the time of treatment

Please complete both sides

Answer all questions by circling Yes (Y) or No (N)

1. Have you ever taken Fen-Phen? Y N
2. **Do you have or have ever had**
   a. AIDS/HIV……………………………………..Y N
   b. Rheumatic Fever or Rheumatic Heart Disease..Y N
   c. Congenital Heart Disease……………………..Y N
   d. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Heart Surgery, Palpitations, Pacemaker?)…………. Y N
   e. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing?)………………………………..Y N
   f. Seizures, Convulsions, Epilepsy, Fainting, or Dizziness……………………………………. Y N
   g. Bleeding Disorder, Anemia, Bleeding Tendency? Do you bruise easily?.................................... Y N
   h. Liver Disease (Jaundice, Hepatitis)?………… Y N
   i. Kidney Disease?……………………………… Y N
   j. Diabetes?…………………………………….. Y N
   k. Thyroid Disease?..…………………………… Y N
   l. Stomach Ulcers or Colitis?............................... Y N
   m. Arthritis?.. Y N
   n. Glaucoma?.. Y N
   o. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?...................... Y N
   p. Radiation (X-ray) treatment for Cancer?.......... Y N
   q. Sinus or Nasal Problems?................................ Y N
   r. Any disease, drug, or transplant operation that has depressed your immune system?............... Y N
   s. Sexually Transmitted Diseases?....................... Y N
3. **ARE YOU USING ANY OF THE FOLLOWING**?
   a. Antibiotics? ?... Y N
   b. Anticoagulants (Blood Thinners)?................... Y N
   c. Aspirin or Motrin,Aleve,Ibuprofen?................. Y N
   d. High Blood Pressure medications?.................. Y N
   e. Steroids (Cortisone,etc)?................................. Y N

(continued above)

All responses are kept confidential

(continued)

   f. Tranquilizers…………………………………. Y N
   g. Insulin or Oral Anti-Diabetic drugs?.................... Y N
   h. Digitalis,Inderal,Nitroglycerin,other heart drugs?Y N
   i. Are you taking or *have ever taken* **Bisphosphonates** (**Fosomax,Actonel**, or **Boniva** for osteoporosis, or **Arcadia** or **Zometa** for multiple myeloma, or other cancers)?... Y N
   j. Please list any and all medications taken, including prescription medications, over the counter, herbal or holistic, vitamins or holistic remedies:

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____
____
____

4. **ARE YOU ALLERGIC TO OR HAVE HAD AN ADVERSE REACTION TO**:
   a. Local Anesthesia (Novocain,etc)?........................ Y N
   b. Penicillin or other antibiotics?............................. Y N
   c. Sedatives, Barbiturates?...................................... Y N
   d. Aspirin or Ibuprofen?... Y N
   e. Codeine or other pain killers?.............................. Y N
   f. Latex or Rubber Products?................................... Y N
   g. Other Allergies? Please list..………………….. Y N

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5. Do you smoke or chew tobacco?...................................... Y N
6. Is there any past history of Alcohol or Chemical dependency or Emotional disorder that may affect the care we provide?...... Y N
7. Do you have any other disease or condition that you think the doctor should know about?.. Y N
8. **FOR WOMEN ONLY**:
   a. Are you pregnant, or any chance you might be?...Y N
   b. Are you nursing?... Y N
   c. Are you on Hormonal Therapy?.......................... Y N
   d. Are taking Birth Control?.................................... Y N

Dental History

Former Dentist:___________________________ Date of last Dental Visit:________________ Date of last X-rays: _______________

Check (✓) if you have had problems with any of the following:

(Bad Breathe (Food collection between teeth (Periodontal Treatment
(Bleeding gums (Grinding or clenching of teeth (Sensitivity to cold/hot/sweets/biting
(Clicking/popping jaw (Loose teeth or broken fillings (Sores or growths in mouth

Patient Signature

I have reviewed the information on this questionnaire and it is to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will notify the dentist. I authorize the dentist to release all information to secure payment of benefits. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Patient's Signature: ____ **Date**: _________________________ Dr's Initials: _________