WEST SHORE DENTISTRY

Cosmetic • Restorative • Family

Dr. Rajiv Motwani, DMD

Date_____

PATIENT INFORMATION

PATIENT'S NAME_____ _____ _____SEX___BIRTHDATE_____AGE____
Last M First

RESIDENCE: STREET _____CITY_____STATE ___ZIP_____
RESIDENCE OUT OF STATE: _____CITY_____STATE___ZIP_____
TELEPHONE: RESIDENCE _____WORK _____CELL _____
EMAIL ADDRESS: _____SS#_____-_____-_____

SINGLE__MARRIED__WIDOWED__NAME OF SPOUSE _____ IF A MINOR, PARENT'S NAME_____
WHO IS RESPONSIBLE FOR THIS ACCOUNT_____

WHOM CAN WE THANK FOR YOUR REFERRAL?_____

DENTAL INSURANCE INFORMATION

POLICY HOLDER_____DATE OF BIRTH _____

SOCIAL SECURITY #_____ NAME OF EMPLOYER _____

DENTAL HISTORY

WHEN WAS YOUR LAST CLEANING? _____X-RAYS? _____
ARE YOU HAVING ANY DISCOMFORT? _____

UNHAPPY WITH ANY PAST DENTISTRY? …..	**Y**	**N**	SENSITIVE TO HOT/COLD/SWEET/BITE PRESSURE?…..	**Y**	**N**
GRIND YOUR TEETH?……	**Y**	**N**	HAVE TMJ OR HEAR CLICKING IN YOUR JAW? ……	**Y**	**N**
GUMS EVER BLEED?……	**Y**	**N**	EVER HAD GUM TREATMENT? ……	**Y**	**N**
WANT WHITER TEETH?……	**Y**	**N**	EXPERIENCE BAD BREATH/BAD TASTE……	**Y**	**N**

HEALTH HISTORY

OTHER MEDICAL/DENTAL CONCERNS
_____

PERSON TO CONTACT FOR EMERGENCY AND AUTHORIZED TO RELEASE OF MEDICAL INFORMATION TO:
_____ PHONE_____

TURN OVER PLEASE……

HEALTH HISTORY

PHYSICIAN'S NAME_____

Date of last visit _____ Any special care? _____

(Women Only) PREGNANT NOW?……..**Y N** (Women) BIRTH CONTROL PILLS?……..**Y N**

CIRCLE ANY **BLOOD THINNERS** taken:
COUMADIN ASPIRIN **PLAVIX**
MOTRIN ARTHRITIS MEDS

CIRCLE ANY **CALCIUM MEDICATION/SUPPLEMENTS** taken:
ACTONEL AREDIA BONIVA FOSAMAX LORON
BONDRONAT BONEFOS RECLAST ZOMETA

LIST ALL OTHER MEDICATIONS YOU TAKE:

_____

_____

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS OR DISEASES?

ARTIFICIAL HEART VALVE OR STINTS……..**Y N**
BI-PASS SURGERY (ARTIFICIAL VEINS)……**Y N**
MITRAL-VALVE PROLAPSE/PACEMAKER ……**Y N**
AIDS/HIV/HEPATITIS A/B/C ……**Y N**
CANCER/RADIATION THERAPY ……**Y N**
HIGH BLOOD PRESSURE……..**Y N**
BLEEDING PROBLEMS ……..**Y N**

ARTIFICIAL JOINT (KNEE, HIP, SHOULDER)……..**Y N**
HEART MURMUR/RHEUMATIC FEVER……**Y N**
ANGINA……..**Y N**
ASTHMA……..**Y N**
DIABETES ……..**Y N**
EPILEPSY/SEIZURES……..**Y N**
VENEREAL DISEASE……..**Y N**

LIST ANY **ALLERGIC REACTIONS** TO MEDICATIONS, ANESTHETICS, METALS, LATEX, ANTIBIOTICS OR OTHER_____

THE INFORMATION GIVEN ABOUT MY HEALTH HISTORY IN THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE CONSENT TO PERFORM NECESSARY DIAGNOSTIC TEST (INCLUDING X-RAYS) AND RELEASE OF THESE RECORDS TO SPECIALISTS OR INSURANCE CARRIERS, IF THE NEED ARISES.
I WILL BE RESPONSIBLE FOR REASONABLE ATTORNEY FEES INCURRED IN COLLECTION OF THIS ACCOUNT, IF NEEDED.

_____ _____
SIGNATURE **DATE**

(STAFF USE ONLY)

DATE	PROVIDER	COMMENTS	PATIENT SIGNATURE