PIERRE M. GHATTAS, D.D.S., L.L.C.

General Dentistry Emphasizing Family, Cosmetic, & Implant Supported Dentures and Crowns

Patient's Last Name First MI Preferred Name Sex Age Marital Status

Street Address City State Zip Home Phone

__/__/_____ - ____ - _____

Patient's Birth Date Social Security Number E-mail Cell Phone

Employer Business Phone Dental Insurance Company Ins. Subscriber

Dental Insurance Address Ins. Phone Group #

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Spouse/Parent/Guardian Birth Date Social Security Number Employer Business Phone

Who may we thank for referring you to our office_____

It is important that we know about your medical & dental history as many things may have a direct bearing on your Dental Health. We will review the questionnaire & discuss it with you in detail, if necessary.

YOUR DENTAL HISTORY

Former Dentist_____Phone_____Last Visit_____
ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH ?_____
Please explain any difficulty with dental treatment in the past._____
What are your fears of dentistry, if any?_____

YOUR MEDICAL HISTORY

Physician's Name_____Phone_____
Are you presently or have you been under the care of a physician during the last year? Yes____ No____
If yes, please explain._____
List all allergies to **DRUGS, FOODS, LATEX (RUBBER), METALS,** etc._____
Have you been instructed by your Physician to **Premedicate with Antibiotics**?_____**Reason?**_____
List any medications you are now taking _____
Have you ever had or been suspected of having any of the following? **Please read each item carefully & *INITIAL ONLY if yes***.

__Allergic to Ibuprofen
__Allergic to Latex
__Allergic to Metals
__Allergic to Any Anesthetics
__Allergic to Penicillin
__Anemia
__Asthma
__Aspirin Therapy
__Arrhythmia(Irregular Heart Beat)
__Blood Disease
__Cancer Therapy
__Crohn's Disease
__Taking Bisphosphonates (Fosomax/Actinol)

__Colitis
__Diabetes-Type I
__Epileptic Seizures
__Fainting Tendency
__Heart Murmur
__Heart Problems
__Hemophilia
__Hepatitis
__HIV Positive
__High Blood Pressure
__Joint Replacement
Date of surgery_____

__TMJ/Jaw Problems
__Kidney or Bladder Problems
__Lupus Erythematosus
__Mitral Valve Prolapse
__Operations
__Orthodontics (braces)
__Pacemaker
__Periodontal Surgery
__Radiation Treatments
__Respiratory Problems
__Rheumatic Fever
__Rheumatoid Arthritis

__Sinus Problems
__Stomach Problems
__Stroke
__Substance Abuse
__Tuberculosis
__Any Back Problems
__Oral Piercing
Date of piercing_____
__Bacterial Endocarditis
__Are you Pregnant
__Other_____
_____

My signature signifies that I understand the following:

- ***This history will not be released without my permission.***
- ***I consent to treatment and understand that I am responsible for all fees regardless of insurance.***
- ***A $35.00 fee may be assessed for missed appointments without a 24 hour notice.***

Date:_____Signature:_____