DR. NEEL BHATAVADEKAR

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Diplomate, American Board of Periodontology

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PATIENT INFORMATION

Today's date___________________
Mr. Mrs. Ms. Miss Dr. ____ Date of Birth____________Age_________
(circle one)
How do you wish to be addressed (nickname) ____

Home Address____
(street) (city) (state) (zip code)

Home Phone #________________________ Cell/Pager #___________________________

Marital Status: M S

Your Employer __________________________________ Occupation ____

Work Phone #______________________________________ School Name if student ________________________________

Emergency contact ______________________________ Relation _____________Phone #___________________________

**************************************REFERRAL INFORMATION**************************************
Have we previously seen any of your family members? If so, who ? ____

Who may we thank for referring you to our office?____

Name of family Dentist____ Phone ______________________

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RESPONSIBLE PARTY INFORMATION
( ) check here if it is the patient

Person responsible for payment________________________________Relationship____________Date of Birth___________

Address ____Phone______________________

Employer__________________________Employer Phone _____________________

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Payment is due at the time services are rendered unless prior arrangements have been made.

Please answer the Medical History questions on the next page.

HEALTH HISTORY

ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

ALL RESPONSES ARE KEPT CONFIDENTIAL

1. Are you in good health?..Y N
2. Has there been any change in your general health in the past year?....................................Y N
3. Date of last physical exam
4. Are you now under a physician's care for a particular problem?..Y N
5. **Have you ever had any illnesses, operations or hospitalizations? If so, describe:**.......Y N

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6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease?.................................. Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?)................................ Y N
     If yes, does your Doctor recommend that you take antibiotics prior to dental treatment…………… Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.. ..Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.......... ..Y N
   - G. Liver Disease (Jaundice, Hepatitis)?...................... Y N
   - H. Kidney Disease?.. .Y N
   - I. **Diabetes?**.. Y N
   - J. Thyroid Disease (Goiter)?.................................... .Y N
   - K. Arthritis?... .Y N
   - L. Stomach Ulcers or Colitis?................................... .Y N
   - M. Glaucoma?... .Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?..................Y N
     If Yes, when? ___________________________________
   - O. Radiation (X-ray) treatment for Cancer?................ Y N
     If Yes, when? ___________________________________
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?......Y N
   - Q. Sinus or Nasal problems?...................................... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? Y N

7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?..Y N
   - B. Anticoagulants (Blood Thinners)?...........................Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - D. High Blood Pressure medications?.........................Y N
   - E. Steroids (Cortisone, etc.)?.....................................Y N
   - F. Tranquilizers?...Y N
   - G. Insulin or Oral Anti-Diabetic drugs?.......................Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug?..Y N
   - I. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:

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8. **ARE YOU ALLERGIC TO OR HAVE YOU 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 or reactions? Please, list..............Y N

     ____

     Or allergy to egg, soy, or other foods?..................Y N
     ____
     ____

9. **Do you smoke or chew Tobacco?.................................**Y N
   How much per day?
10. Is there any past history of Alcohol or Chemical

11. Have you had any serious problems with prior dental treatment?

13. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant?...Y N
    - B. Are you nursing?...Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance. ______initials

Please state the chief reason for todays visit:____

I HAVE COMPLETED THE ABOVE FORM ACCURATELY AND TO THE BEST OF MY KNOWLDEGE

Signature of patient

Signature of Doctor

Name of patient: