JOHN R. FOGAROS, D.D.S.
COSMETIC AND GENERAL DENTISTRY

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WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you.

We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

DATE _____

Name _____ SSN # _____

Home Phone _____ Cell Phone _____ Email Address _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Other

Patient Employed By _____ Occupation _____ Business Phone _____

Business Address _____

In case of emergency who should be contacted? _____ Phone _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Person Responsible For Account _____

Relation to Patient _____ Birth Date _____ SS# _____

Address (if different from patients) _____ Phone # _____

Employer _____ Occupation _____ Work Phone _____

Insurance Company _____ Contact # _____ Group # _____

Subscriber # (if different than SS#) _____ Do you have other dental insurance? _____

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

TO BETTER SERVE YOU

Reason for Today's Visit _____

Date of Last Dental Treatment _____ Date of Last Dental X-Rays _____ Former Dentist _____

If you could change something about your smile, what would it be? _____

_____

DENTAL HISTORY

Check if you have any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking of Popping Jaw
- ☐ Food Collection Between Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth of Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Sores or Growths in Your Mouth

How Often Do You Floss?_____

How Often Do You Brush? _____

Do You Have Any Other Concerns? _____

_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit_____

Do you require an antibiotic before dental treatment? ☐ YES ☐ NO

Have You Had Any Serious Illnesses or Operations? ☐ YES ☐ NO If Yes, Please Describe_____

Have You Ever Had A Blood Transfusion? ☐ YES ☐ NO If Yes, Approximate Date(s)_____

Are You Pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking Birth Control Pills ☐ YES ☐ NO

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS	Cough, Persistent	High Blood Pressure	Skin Rash
Anemia	Cough up Blood	HIV Positive	Stomach Problems
Arthritis	Diabetes	Jaw Pain	Stroke
Artificial Heart Valve	Epilepsy	Kidney Disease	Swelling of Feet or Ankles
Artificial Joints	Excessive Bleeding	Liver Disease	Thyroid Problems
Asthma	Fainting	Mitral Valve Prolapse	Tobacco Habit
Back Problems	Glaucoma	Nervous Problems	Tuberculosis
Blood Disease	Headache	Pacemaker	Ulcer
Cancer	Heart Murmur	Radiation Treatment	Venereal Disease
Chemical Dependency	Heart Problems	Respiratory Disease	Any Other Conditions not listed:
Circulatory Problems	Hemophilia	Rheumatic Fever	_____
Cortisone Treatment	Hepatitis	Shortness of Breath	_____

PLEASE LIST ALL ALLERGIES:

_____

_____

_____

_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____