

CINDY BOGDANOFF, D.D.S. and STAN EISENBERG, D.D.S.
HEALTH HISTORY & REGISTRATION

Patient's Name: _____ Sex: M F DOB: _____ Age: _____ Date: _____
 Home Address: _____ City/State/Zip _____
 Please Select: Single Married Separated Divorced Widowed Home #: _____ Cell #: _____
 Your Employer: _____ How Long? _____ Your SS#: _____ Work #: _____
 Full Time Student: Yes No **If Patient is a minor we need: Mother's DOB: _____ Father's DOB: _____**
 Name of Spouse (Parent if patient is a minor) _____ Person Responsible for Acct. _____
 Spouse's (Parents') Employer: _____ Spouse's SS#: _____ Work #: _____
EMERGENCY INFORMATION: Name, Address & Phone # of a relative NOT living with you _____
 Email: _____
 Referred to us by _____

DENTAL INSURANCE INFORMATION	
Insured's Name: _____	YES NO <input type="checkbox"/> <input type="checkbox"/> Heart Failure
Insurance Company: _____	<input type="checkbox"/> <input type="checkbox"/> Heart Disease or Attack
Insured's Employer: _____	<input type="checkbox"/> <input type="checkbox"/> Blood Thinners
Insured's SSN _____ Group # _____	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
ID # _____	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur/MVP
	<input type="checkbox"/> <input type="checkbox"/> Angina Pectoris
	<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Lesions
	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever
	<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve
	<input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker
	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery
	<input type="checkbox"/> <input type="checkbox"/> Artificial Joints (hip, knee)
	<input type="checkbox"/> <input type="checkbox"/> Anemia
	<input type="checkbox"/> <input type="checkbox"/> Stroke
	<input type="checkbox"/> <input type="checkbox"/> Kidney Trouble
	<input type="checkbox"/> <input type="checkbox"/> Ulcers
	<input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery
	<input type="checkbox"/> <input type="checkbox"/> Bruise Easily
	<input type="checkbox"/> <input type="checkbox"/> Emphysema
	<input type="checkbox"/> <input type="checkbox"/> Asthma
	<input type="checkbox"/> <input type="checkbox"/> Sinus Trouble
	<input type="checkbox"/> <input type="checkbox"/> Diabetes
	<input type="checkbox"/> <input type="checkbox"/> X-ray/Cobalt Treatments
	<input type="checkbox"/> <input type="checkbox"/> Rheumatism
	<input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints
	<input type="checkbox"/> <input type="checkbox"/> Bleeding Problems
	<input type="checkbox"/> <input type="checkbox"/> H.I.V. Positive A.I.D.S
	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A or C (infectious)
	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B (serum)
	<input type="checkbox"/> <input type="checkbox"/> Liver Disease
	<input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice
	<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion
	<input type="checkbox"/> <input type="checkbox"/> Drug Addiction
	<input type="checkbox"/> <input type="checkbox"/> Hemophilia
	<input type="checkbox"/> <input type="checkbox"/> Fever Blisters
	<input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures
	<input type="checkbox"/> <input type="checkbox"/> Fainting or Dizzy Spells
	<input type="checkbox"/> <input type="checkbox"/> Nervousness
	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment
	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease
	<input type="checkbox"/> <input type="checkbox"/> Glaucoma
	<input type="checkbox"/> <input type="checkbox"/> Macular Degeneration
	<input type="checkbox"/> <input type="checkbox"/> Chemotherapy (Cancer, Leukemia)
	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis (TB)
	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever
	<input type="checkbox"/> <input type="checkbox"/> Allergies, Hives or Hay Fever
	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease
	<input type="checkbox"/> <input type="checkbox"/> Arthritis
	<input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine
	<input type="checkbox"/> <input type="checkbox"/> Alcoholism
	<input type="checkbox"/> <input type="checkbox"/> Reflux
	<input type="checkbox"/> <input type="checkbox"/> Alzheimer's
	Have you ever Pre-Medicated for dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you allergic or have you reacted adversely to any of the following?
	YES NO YES NO YES NO
	<input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> Percodan <input type="checkbox"/> <input type="checkbox"/> Erythromycin
	<input type="checkbox"/> <input type="checkbox"/> Z Pack <input type="checkbox"/> <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> <input type="checkbox"/> Valium
	<input type="checkbox"/> <input type="checkbox"/> Nitrous Oxide <input type="checkbox"/> <input type="checkbox"/> Codeine <input type="checkbox"/> <input type="checkbox"/> Penicillin
	Are you aware of being allergic to any other medication or substance?
	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:
	MEDICAL HISTORY YES NO
Do you have CURRENT HEALTH PROBLEMS?	<input type="checkbox"/> <input type="checkbox"/>
Are you under a PHYSICIAN'S CARE now? If yes, for what reason?	<input type="checkbox"/> <input type="checkbox"/>
Are you currently taking Medications? If yes, What?	<input type="checkbox"/> <input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/> <input type="checkbox"/>
Do you smoke?	<input type="checkbox"/> <input type="checkbox"/>
Do you feel you have bad breath?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever had Botox and or Dermal Fillers in the past?	<input type="checkbox"/> <input type="checkbox"/>
Family Physican:	
Phone:	
Is there any other Medical or Dental information that you feel we should know about?	

CONSENT: The undersigned hereby authorizes the Dentist to take X-ray, study models, photographs, or any other diagnostic aids deemed appropriate by the Dentist to make a through diagnosis of the patient's dental needs. I also authorize the Dentist to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Dentist.

Patient's Signature (Parent of Child): _____ Date _____ Dentist's Signature: _____