Welcome to the office of
Leonid R Briskin, DMD

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Information

Name_____ SS# _____-_____-_____
Last First MI E-mail: _____
Address_____City_____
State_____ Zip _____ Home Phone (_____) _____-_____ Cellular Phone (_____) _____-_____
Sex M F Age _____ Birth date ___/___/_____ Single Married Widowed Separated Divorced
Employer _____ Occupation _____
Business Address_____ Work Phone (_____) _____-_____ext.____
Whom may we thank for referring you? _____
Person to notify in case of an emergency _____ Home Phone (_____) _____-_____
Work Phone (_____) _____-_____

Dental History

Reason for your visit? _____ Are you in dental discomfort today? _____
Former Dentist _____Address _____ Phone(____)____-_____
Date of last dental visit___/_____
Do you have any of the following problems?:

Food collection between teeth	Periodontal treatment	Loose teeth	Broken fillings
Bleeding gums	Sensitivity to cold / hot	Sensitivity when biting	Clicking or popping jaw
Sensitivity to sweets	Sores in mouth	Bad Breath	

How often do you **brush**? _____/day **floss**? _____/day
Have you ever experienced any adverse reaction to dental anesthesia? Yes No
How do you feel about appearance of your smile? _____
What, if anything, would you like to change about you smile/teeth? _____
Is there anything else you would like us to know about your dental history? Yes No_____
_____

Dental Insurance Information

PRIMARY INSURANCE:
Insured's Name (Last, First, MI): _____
Relationship to patient_____ Birth date ___/___/_____ SS# _____-____-_____
Address (if different from patient) _____
City_____ State_____ Zip _____ Home Phone (_____) _____-_____
Employer _____ Occupation _____
Business Address_____ Phone (_____) _____-_____ext._____
Insurance company_____ Phone (_____) _____-_____
Group Name _____ Group # _____ Subscriber/ID # _____
Names of other dependents covered by this plan _____
SECONDARY INSURANCE: Yes No
Insured's Name (Last, First, MI): _____
SS#_____-____-_____ Birth date ____/____/_____
Employer _____ Phone (_____) _____-_____ext.___
Insurance company_____ Phone (_____) _____-_____
Group Name _____ Group # _____ Subscriber/ID # _____

Medical History

Physician's name _____ Phone(_____)_____-_____ Date of last visit___/___/_____
Are you currently under physician's care? Yes No If yes, describe _____
Have you ever been hospitalized or had a major operation? Yes No If yes, describe _____
Have you ever had a serious head or neck injury? Yes No If yes, describe _____
Have you ever taken **Fosamax, Alendronate, Boniva, Actonel, Zometa, Aclasta, Aredia, Reclasp** or other medications containing **bisphosphonates**? Yes No If yes, describe _____
Are you on a special diet? Yes No If yes, describe _____
Do you use tobacco? Yes No Do you use alcohol? Yes No # of drinks per week_____
Women: Are you pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Do you have or have you ever had any of the following?:

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Kidney Problems	Scarlet fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Glaucoma	Leukemia	Shingles
Anaphylaxis	Congenital Heart Disorder	Hay Fever	Liver Disease	Sickle Cell Disease
Anemia	Convulsions	Heart Attack/Failure	Low Blood Pressure	Sinus Trouble
Angina	Cortisone Medicine	Heart Murmur	Lung Disease	Spinal Bifida
Arthritis/Gout	Diabetes	Heart Pace Maker	I've read these questions	Stomach/Intestinal Disease
Artificial Heart Valve	Drug Addiction	Heart Trouble/Disease	Mitral Valve Prolapse	Stroke
Artificial joint	Easily Winded	Hemophilia	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hepatitis A	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis B or C	Psychiatric Care	Tuberculosis
Blood Transfusion	Excessive Bleeding	Herpes	Radiation Treatments	Tumors or Growths
Breathing Problem	Excessive Thirst	High Blood Pressure	Recent Weight Loss	Ulcer
Bruise Easily	Fainting Spells/Dizziness	Hives or Rash	Renal Dialysis	Jaundice (Yellow)
Cancer	Frequent Cough	Hypoglycemia	Rheumatic Fever	High Cholesterol
Chemotherapy	Frequent Diarrhea	Irregular Heartbeat	Rheumatism	Venereal Desease
		Implants / Transplants		

Are you **allergic** to any of the following?

Aspirin	Penicillin	Codeine	Acrylic	Metal	Erythromycin	Local Anesthetics
Iodine	Barbiturates	Valium	Sulfa	Latex	Household Bleach	Advil/Motrin

Other _____

List **medications, pills or drugs** you are currently taking:_____
_____
List **any condition** you have that was not mention above: _____
_____

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

FEES WILL BE ASSESSED FOR **RETURNED CHECKS** AND FOR **APPOINTMENTS FAILED** OR **NOT CANCELLED WITHIN 24 HOURS.**

_____ _____
Signature of patient or parent/legal guardian if minor Date
Reviewed By_____ Date_____