SAMANTHA BESSER, D.M.D

PRACTICE LIMITED TO ENDODONTICS

PLEASE PRINT THE FOLLOWING INFORMATION

DATE: _____

PATIENT NAME: _____
Last First Middle

STREET ADDRESS: _____
Number City/State Zip

HOME PHONE( )_____WORK PHONE( )_____ DRIVER LIC.#_____

SOCIAL SECURITY#_____ BIRTHDATE _____ MARITAL STATUS_____

EMPLOYER'S NAME _____ OCCUPATION_____

EMPLOYER'S ADDRESS_____

DO YOU HAVE DENTAL INSURANCE? IF SO, WHAT IS THE NAME: _____

DO YOU HAVE A SECONDARY INSURANCE? IF SO, WHAT IS THE NAME: _____

WHO IS THE RESPONSIBLE PARTY UNDER YOUR INSURANCE PLAN? _____

INSURED'S SOCIAL SECURITY #: _____INSURED'S BIRTHDATE: _____

INSURED'S EMPLOYER NAME AND ADDRESS: _____

_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Have you ever had any of the following? Please circle Yes or No.

YES NO 1. DO YOU CONSIDER YOURSELF A HEALTHY PERSON?

YES NO 2. HAVE YOU BEEN EXAMINED BY A PHYSICIAN IN THE LAST YEAR?

YES NO 3. SERIOUS ILLNESS?

YES NO 4. HIGH BLOOD PRESSURE?

YES NO 5. HEART PROBLEM? (i.e. ATTACK, MURMUR, STROKE, ETC.)

YES NO 6. RHEUMATIC FEVER; MITRAL VALVE PROLAPSE?

YES NO 7. PROSTHETIC HEART VALVE?

YES NO 8. ARTIFICIAL JOINTS?

YES NO 9. TUBERCULOSIS, EMPHYSEMA OR ASTHMA?

YES NO 10. LIVER DISEASE (i.e. HEPATITIS)

YES NO 11. KIDNEY DISEASE?

YES NO 12. ULCERS?

YES NO 13. DIABETES?

YES NO 14. THYROID DISEASE?

YES NO 15. FITS, CONVULSIONS, SEIZURES, OR DIZZINESS?

YES NO 16. VENEREAL DISEASE?

YES NO 17. BLISTERS/ SORES IN MOUTH?

YES NO 18.BLOOD DISORDER? (i.e. ANEMIA)

YES NO 19.BLEEDING OR INFECTED GUMS?

YES NO 20. DO YOU ACTIVELY ENGAGE IN HIGH RISK BEHAVIOR FOR INFECTIOUS DISEASES? (i.e. AIDS, HEPATITIS, AND/OR ARE YOU OR HAVE BEEN *HIV POSITIVE*)

YES NO 21. HAVE YOU EVER BEEN TREATED FOR CANCER?

YES NO 22. HAVE YOU EVER HAD RADIATION TREATMENT?

YES NO 23. HAVE YOU EVER HAD INJURY TO THE HEAD, NECK, JAW OR TEETH?

YES NO 24. SURGERY?

YES NO 25. ARE YOU EASILY UPSET?

YES NO 26. DO YOU CONSIDER YOURSELF A NERVOUS PERSON?

YES NO 27. HAVE YOU USED COCAINE OR "CRACK" WITHIN THE LAST SIX MONTHS?

YES NO 28. DO YOU SMOKE OR USE TOBACCO?

YES NO 29. DO YOU DRINK ALCOHOL DAILY?

YES NO 30. HAVE YOU EVER TAKEN PHEN-PHEN?

YES NO 31. WOMEN- ARE YOU PREGNANT?

YES NO 32. WOMEN- ARE YOU TAKING BIRTH CONTROL PILLS?

YES NO 33. ARE YOU SENSITIVE OR ALLERGIC TO ANY MEDICATIONS? IF SO PLEASE INDICATE:

_____

YES NO 34. PLEASE LIST THE MEDICATIONS YOU ARE TAKING.

_____

YES NO 35. ARE YOU ALLERGIC TO LATEX? (powdered rubber glove)

YES NO 36. ARE YOU HERE TODAY FOR A SPECIALIST CONSULTATION AND/OR TREATMENT?

PLEASE LIST ALL HOSPITALIZATIONS:

REASON:	YEAR:
_____	_____
_____	_____
_____	_____

I HEREBY INSTRUCT AND DIRECT MY INSURANCE TO REIMBURSE DR. BESSER/ PERSONAL DENTAL OFFICE FOR SERVICES RENDERED.
I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER, OR ATTORNEY INVOLVED IN THIS CASE.

I HAVE READ AND UNDERSTOOD THE ABOVE QUESTIONNAIRE AND HAVE ANSWERED ALL QUESTIONS TRUTHFULLY TO THE BEST OF MY ABILITY. IF EVER MY HEALTH OR MEDICATIONS CHANGE, I WILL NOTIFY MY DENTIST AT MY NEXT APPOINTMENT.

_____ _____

PATIENT'S SIGNATURE **DATE**

_____ _____

POLICY HOLDER'S SIGNATURE (IF OTHER THAN PT.) **DATE**

IF UNABLE TO KEEP APPOINTMENT, KINDLY GIVE (AT LEAST) 24 HOURS NOTICE, OTHERWISE THERE WILL BE A $50.00 CHARGE FOR SAME DAY CANCELLATIONS OR NO SHOW

SAMANTHA BESSER D.M.D

TOOTH AND PAIN HISTORY

Dear Patient: Please check the statement that best describes or relates to your condition.

Patient Name: _____

1. _____ My dentist said I need root canal therapy.
2. _____ My dentist worked on the tooth _____. When?_____
3. _____ When drilling the tooth, the dentist reached the nerve, or very close to it.
4. _____ I never had any pain.
5. _____ I have had pain.
6. _____ I am here for treatment of present pain.
7. _____ I first noticed the pain ____ days ____ weeks ____ months ago.
8. _____ The pain is decreasing or has disappeared.
9. _____ The pain occurs spontaneously.
10. _____ The pain occurs at night.
11. _____ The pain comes and goes.
12. _____ The pain is increased or decreased by cold drinks or ice.
13. _____ The pain is increased by heat.
14. _____ The pain is associated with eating or chewing.
15. _____ Sweet and sour food cause pain.
16. _____ The pain is steady.
17. _____ The gum and jaw are painful.
18. _____ The pain is spreading to the ear/ eye/ temples/ head/ or neck.
19. _____ I feel pain on the whole side of my face.
20. _____ I have had/ or have swelling.
21. _____ I feel that my mouth opening is restricted.
22. _____ I am presently on antibiotics/ pain medication.
23. _____ The tooth feels elongated and sore to touch.
24. _____ The tooth feels lose.
25. _____ I have a strange taste in my mouth.
26. _____ I have/ had a gum blister or boil.
27. _____ Other: _____

_____