ELITE
DENTAL & AESTHETICS

Welcome to our practice. We look forward to providing you with excellent care in dentistry and facial aesthetics. Please fill out the following information so we may best serve you.

Dr. Carolina Borgenicht • Dr. Santiago Lopez • Dr. Jack Behn

PATIENT INFORMATION

TODAY'S DATE: _____/_____/_____

FIRST NAME: _____ LAST NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTRY: _____

AGE: _____ DATE OF BIRTH (mm/dd/yy): _____/_____/_____ SEX: ☐M ☐F

MARITAL STATUS: ☐ Single ☐ Married SOCIAL SECURITY #: _____-_____-_____

EMAIL ADDRESS (For our office use only): _____

HOME PH #: (_____)_____ CELL PH #: (_____)_____ WORK PH #: (_____)_____

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTRY: _____

HOW DID YOU HEAR ABOUT US? REFERRAL: Who may we thank for recommending us? _____

ONLINE: ☐google ☐facebook ☐other online source: _____

EVENT: ☐seminar ☐bridal show ☐spa event ☐school event

MAILING: ☐magazine ☐postcard

EMERGENCY CONTACT

NAME OF PERSON WE SHOULD CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ HOME PH #: (_____)_____ CELL PH #: (_____)_____

BILLING INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT ☐ SELF ☐ PARENT/GUARDIAN ☐OTHER _____

BILLING ADDRESS (if different from patient's address)_____

CITY: _____ STATE: _____ ZIP: _____ COUNTRY: _____

DENTAL INSURANCE? ☐Y ☐N INSURANCE COMPANY: _____ PHONE #: _____

NAME OF INSURED: ☐ SELF ☐ OTHER _____

RELATIONSHIP: _____ DATE OF BIRTH (mm/dd/yy): _____

SOCIAL SECURITY #: _____–_____–_____

PATIENT FULL NAME: _____ PATIENT SIGNATURE: _____

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YOUR MEDICAL INFORMATION

Name of primary doctor: _____ Phone number: _____

Are you under a physician's care for any medical condition? ☐Y ☐N If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐Y ☐N If yes, please explain: _____

PLEASE LIST ALL THE **MEDICATIONS**, PILLS, OR DRUGS THAT YOU ARE TAKING: _____

_____

ARE YOU **ALLERGIC** TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs ☐ Local Anesthetics

☐ Other allergies _____

Have taken Phen-Fen or Redux? ☐Y ☐N Have you taken Fosamax,Boniva, or Actonel? ☐Y ☐N

Do you drink alcohol? ☐Y ☐N If yes, how much/how often? _____

Do you smoke or use tobacco? ☐Y ☐N If yes, how much/how often? _____

WOMEN ONLY: Are you pregnant or trying to get pregnant? ☐Y ☐N If pregnant, how many weeks? _____

Are you taking oral contraceptives? ☐Y ☐N Are you nursing? ☐Y ☐N

In order to safely treat you and make proper diagnoses, it is important that we know your medical conditions.

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐Y ☐N	Cortisone Medicine ☐Y ☐N	Hepatitis A ☐Y ☐N	Renal Dialysis ☐Y ☐N
Alzheimer's Disease ☐Y ☐N	Diabetes ☐Y ☐N	Hepatitis B or C ☐Y ☐N	Rheumatic Fever ☐Y ☐N
Anaphylaxis ☐Y ☐N	Drug Addiction ☐Y ☐N	Herpes ☐Y ☐N	Rheumatism ☐Y ☐N
Anemia ☐Y ☐N	Easily Winded ☐Y ☐N	High Blood Press. ☐Y ☐N	Scarlet Fever ☐Y ☐N
Angina ☐Y ☐N	Emphysema ☐Y ☐N	High Cholesterol ☐Y ☐N	Shingles ☐Y ☐N
Arthritis/Gout ☐Y ☐N	Epilepsy or Seizures ☐Y ☐N	Hives or Rash ☐Y ☐N	Sickle Cell Disease ☐Y ☐N
Artificial Heart Valve ☐Y ☐N	Excessive Bleeding ☐Y ☐N	Hypoglycemia ☐Y ☐N	Sinus Trouble ☐Y ☐N
Artificial Joint ☐Y ☐N	Excessive Thirst ☐Y ☐N	Irregular Heartbeat ☐Y ☐N	Spina Bifida ☐Y ☐N
Asthma ☐Y ☐N	Fainting/Dizziness ☐Y ☐N	Kidney Problems ☐Y ☐N	Stomach/GI Disease ☐Y ☐N
Blood Disease ☐Y ☐N	Frequent Cough ☐Y ☐N	Leukemia ☐Y ☐N	Stroke ☐Y ☐N
Blood Transfusion ☐Y ☐N	Frequent Diarrhea ☐Y ☐N	Liver Disease ☐Y ☐N	Swelling of Limbs ☐Y ☐N
Breathing Problem ☐Y ☐N	Frequent Headaches ☐Y ☐N	Low Blood Pressure ☐Y ☐N	Thyroid Disease ☐Y ☐N
Bruise Easily ☐Y ☐N	Genital Herpes ☐Y ☐N	Lung Disease ☐Y ☐N	Tonsillitis ☐Y ☐N
Cancer ☐Y ☐N	Glaucoma ☐Y ☐N	Mitral Valve Prolapse ☐Y ☐N	Tuberculosis ☐Y ☐N
Chemotherapy ☐Y ☐N	Hay Fever ☐Y ☐N	Osteoporosis ☐Y ☐N	Tumors of Growth ☐Y ☐N
Chest Pain ☐Y ☐N	Heart Attack/Failure ☐Y ☐N	Pain in Jaw Joints ☐Y ☐N	Ulcers ☐Y ☐N
Cold Sores/Fever Blister ☐Y ☐N	Heart Murmur ☐Y ☐N	Parathyroid Disease ☐Y ☐N	Venereal Disease ☐Y ☐N
Congenital Heart Disorder ☐Y ☐N	Heart Pace Maker ☐Y ☐N	Psychiatric Care ☐Y ☐N	Yellow Jaundice ☐Y ☐N
Convulsions ☐Y ☐N	Heart Trouble/Disease ☐Y ☐N	Radiation Treatments ☐Y ☐N	

Have you ever had any serious illness not listed above? ☐Y ☐N If yes, please explain: _____

Do you need to be premedicated before dental treatment? ☐Y ☐N If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to the health of the patient. It is my responsibility to inform this office of any changes in my medical status.

SIGNATURE OF PATIENT (or Parent/Guardian): _____ DATE: _____/_____/_____

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PLEASE TELL US ABOUT YOUR SMILE

What is the primary reason for your visit today? _____

When was your last dental cleaning? _____ When was your last dental x-ray? _____

Do you brush regularly? ☐Y ☐N Do you floss regularly? ☐Y ☐N

Have you had a bad reaction at the dentist in the past? ☐Y ☐N If yes, to what? _____

Your anxiety level at the dentist is: ☐Low ☐Medium ☐High ☐Very high

How happy are you with your smile? ☐ Very happy ☐ It's just OK ☐ Could be nicer

Please answer every question below:		**Comments:**
Do your gums bleed when brushing/flossing?	☐Y ☐N	_____
Are you currently experiencing dental pain?	☐Y ☐N	_____
Do you grind or clench your teeth?	☐Y ☐N	_____
Do you currently wear a nightguard when you sleep?	☐Y ☐N	_____
Do you get frequent headaches?	☐Y ☐N	_____
Do you suffer from TMJ symptoms or pain?	☐Y ☐N	_____
Are you interested in implants to replace missing teeth?	☐Y ☐N	_____
Are you interested in whitening your teeth?	☐Y ☐N	_____
Are you interested in straightening your teeth?	☐Y ☐N	_____
Are you interested in fuller lips?	☐Y ☐N	_____
Are you interested in improving the lines/wrinkles around your mouth?	☐Y ☐N	_____

Is there something about your smile that you would like to improve? _____

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the dentist and his staff, and I assume all financial responsibility for treatment given, services rendered and all associated costs incurred as a result of my treatment. I acknowledge that all the information contained herein is true and correct and give my permission to verify any of the information provided. I, the undersigned (patient or legally responsible party), have reviewed the HIPAA Privacy Policy Notice available in the office of Elite Dental & Aesthetics.

SIGNATURE OF PATIENT (or Parent/Guardian): _____ DATE: _____/_____/_____