Welcome

Solon Smiles

Dr. Vladimir Khramoy D.D.S
Dr. Ellen Friedman D.M.D.

Age:_____
Today's Date:_____
Patient/Parent SSN#:_____
Spouse SSN#:_____

Patients Name_____Date of Birth_____ **O** Male **O** Female
Last First Initial
If Child: Parents name_____**O** Single **O** Married **O** Separated **O** Divorced **O** Widowed **O** Minor

Street_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____Email:_____

If Student, Name of school/College_____City_____State_____**O** Full Time **O** Part Time

Patient/Parent Employed By_____Present Position_____How Long Held_____

Spouse/Parent Name_____Spouse Employed By_____

Present Position _____How Long Held_____

Purpose Of Call _____Who may we thank for this referral?_____

Emergency Contact?_____Telephone#: _____

RESPONSIBLE PARTY

Who is Responsible for this account_____
For your convenience, we offer the following methods of payments. Please check the option you prefer:
O Cash **O** Personal Check **O** Credit Card **O** Care Credit

INSURANCE INFORMATION

Employee Name:_____Date of Birth:_____ Relationship to patient:_____
Employer Name:_____How long held_____
Name of Insurance Co._____Address:_____
Telephone_____Subscriber Id#_____Group #_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? O YES O NO IF YES COMPLETE THE FOLLOWING:

Employee Name:_____Date of Birth:_____ Relationship to patient:_____
Employer Name:_____How long held_____
Name of Insurance Co._____Address:_____
Telephone_____Subscriber Id#_____Group #_____

PATIENT MEDICAL HISTORY

Physician_____Office Phone#_____Date of last Exam_____

	YES	NO
1. Are you under medical treatment now?.....	O	O
2. Have you ever been hospitalized for any surgical operation or serious illness within the 5 years?.....	O	O
If yes, please explain:_____		
_____		
3. Are you taking any medications including non-prescription medicine?.....	O	O
If yes, what medications are you taking?_____		
_____		
_____		
4. Are you taking daily Aspirin or Blood Thinners?...	O	O
5. Have you ever taken Fen-Phen/Redux?	O	O
6. Have you in the last 24hours taken Viagra, Revati, Cialis, or Levitra?.....	O	O
7.Have you ever taken Fosmax, Boniva, Actonel, or any other medication for Osteoporosis?.....	O	O
8.Do you use tobacco	O	O
9. Do you use controlled substances?	O	O
10. Do you consume alcohol?	O	O
If yes how many per day?_____		

	YES	NO
11. Are you wearing contact lenses?	O	O
12. Are you allergic to or have you had any reaction to the following?	O	O
Local Anesthetics (Novocaine)	O	O
Penicillin or any other antibiotics	O	O
Sulfa Drugs	O	O
Barbiturates	O	O
Sedatives	O	O
Iodine	O	O
Aspirin	O	O
Any metals (e.g. Nickel, Mercury, etc.)	O	O
Latex Rubber	O	O
Other_____		
13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	O	O
Women Only:		
A) Are you pregnant?	O	O
If yes, how far along_____		
B) Are you nursing?	O	O
C) Are you taking oral contraceptives?	O	O

Do you have or have you had any on the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	O	O	Stroke	O	O	Tuberculosis	O	O
Low Blood Pressure	O	O	Hay Fever/Allergies	O	O	Recent Weight loss	O	O
Heart Attack	O	O	Rheumatic Fever	O	O	Liver Disease	O	O
Heart Disease	O	O	Frequently Tired	O	O	Easily Winded	O	O
Mitral Valve Prolapse	O	O	Anemia	O	O	Respiratory Problems	O	O
Cardiac Peacemaker	O	O	Asthma	O	O	Cancer	O	O
Artificial Heart Valves	O	O	Swollen Ankles	O	O	Radiation Therapy/Chemotherapy	O	O
Stents	O	O	Arthritis	O	O	Problems with mental health	O	O
Joint Replacements or Implants	O	O	Fainting/Seizures	O	O	Thyroid Problem	O	O
Excessive Bleeding	O	O	Epilepsy/Convulsions	O	O	Kidney Disease	O	O
Angina/Chest Pain	O	O	Osteoporosis	O	O	Diabetes	O	O
Auto Immune Disease	O	O	Aids or HIV Infection	O	O	Hepatitis	O	O
Sexually Transmitted Disease	O	O	Other:					

PATIENT DENTAL HISTORY

Name of previous Dentist and Location:_____Date of Last Exam_ _____

	YES	NO
1.Have you ever needed to take antibiotic premeditation before dental visits?	O	O
2. Do your gums bleed while brushing or flossing?	O	O
3. Are your teeth sensitive?	O	O
4. Do you feel pain to any of your teeth?	O	O
5. Do you have any sores or lumps in or near your mouth?	O	O
6. Have you had any head, neck, or jaw injuries?	O	O
7. Have you ever had difficult extractions in the past	O	O
8. Have you had any orthodontic treatment?	O	O
9. Do you often feel TIRED, fatigued or sleepy during daytime?	O	O
10. Do you experience dry mouth?	O	O

	YES	NO
11. Has anyone OBSERVED you stop breathing during your sleep?	O	O
12. Have you ever been diagnosed with Sleep Apnea?	O	O
13. Have you ever experienced any of the following problems with your jaw?	O	O
Clicking	O	O
Pain(joint,ear, side of face)	O	O
Difficulty in opening or closing	O	O
Difficulty in chewing	O	O
14. Do you have frequent headaches?	O	O
15. Do you clench or grind your teeth?	O	O
16. Do you wear any removable appliance?	O	O
If yes date of placement?_____		

AUTHORIZATION AND RELEASE

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT unless prior arrangements have been approved. This office accepts insurance,I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence ant it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I acknowledge receipt of the offices privacy policy. I give my permission to release any medical information if necessary. We do value your time so please value ours if for any reason you needs to cancel or reschedule please do so prior to **24 hours** of your appointment or you will be charged (**$25** for up to an hour) and/or (**$50** per hour of missed appointment.).

X_____ _____