# Krasnodara Gashparova, DDS

## DENTAL REGISTRATION AND HISTORY

### PATIENT INFORMATION

***We are so glad that you chose our office for your dental care!***

Whom may we thank for referring you? ________________________
Date _______________
Patient Name _________________ ___________________ _______
Last Name First Name M.I.
Address ________________________________________________
City __________________________
State ______________ Zip _______________
Phone # ________________________________
Best time to reach you _____________________
E-mail_______________________________________________
Sex ☐ M ☐ F
Birthdate ________________ Social Security # ________________
☐ Single ☐ Married ☐ Minor
Occupation ______________________________________________
Employer/School _________________________________________
Employer/School Address __________________________________
_______________________________________________________
Employer/School Phone # __________________________________

Spouse's (partner's) Name _________________________________
Phone # ________________________________________________

**What is your preferred method of communication?**
☐ Phone call ☐ Text ☐ E-mail

### DENTAL INSURANCE

Who is responsible for this account? __________________________
Relationship to Patient ____________________________________
Insurance Co. __________________________________________
Group # _______________________________________________
Is patient covered by additional/secondary insurance? ☐ Yes ☐ No
Subscriber's Name ________________________________________
Birthdate _________________ SS# ______________________
Relationship to Patient ____________________________________
Insurance Co. __________________________________________
Group # _______________________________________________

**ASSIGNMENT AND RELEASE**

I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me for services rendered, directly to Krasnodara Gashparova DDS Inc.
The above-named dentist may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits.
I authorize the use of my signature on all insurance submissions.

_______________________________________
Signature of Patient, Legal Guardian or Personal Representative

_______________________________________
Please print name of Patient, Legal Guardian or Personal Representative

____________________ ________________________________
Date Relationship to Patient

### EMERGENCY CONTACT

Name ____________________________________________ Relationship _____________________________

Phone # ( ☐ Mobile ☐ Work ☐ Home ) ______________________________________

### HEALTH HISTORY

Reason for today's visit _________________
Former Dentist _________________________
City/State ____________________________
Date of last dental visit _________________
Date of last x-rays ______________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| Condition | Yes | No |
|---|---|---|
| Bad breath | ☐ Yes | ☐ No |
| Bleeding gums | ☐ Yes | ☐ No |
| Blister on lips or mouth | ☐ Yes | ☐ No |
| Burning sensation on tongue | ☐ Yes | ☐ No |
| Chew on one side of mouth | ☐ Yes | ☐ No |
| Cigarette, pipe, or cigar smoking | ☐ Yes | ☐ No |
| Clicking or popping jaw | ☐ Yes | ☐ No |
| Dry mouth | ☐ Yes | ☐ No |
| Food collection between the teeth | ☐ Yes | ☐ No |
| Fingernail biting | ☐ Yes | ☐ No |
| Do you grind your teeth | ☐ Yes | ☐ No |
| Gums swollen or tender | ☐ Yes | ☐ No |
| Jaw pain or tiredness | ☐ Yes | ☐ No |
| Lip or cheek biting | ☐ Yes | ☐ No |
| Mouth breathing | ☐ Yes | ☐ No |
| Mouth pain when brushing | ☐ Yes | ☐ No |
| Orthodontic treatment | ☐ Yes | ☐ No |
| Pain around ear | ☐ Yes | ☐ No |
| Periodontal/gum surgery | ☐ Yes | ☐ No |
| Sensitivity to hot/cold/sweets | ☐ Yes | ☐ No |
| Sensitivity when biting | ☐ Yes | ☐ No |

How often do you floss? _____________

How often to you brush? _____________

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### HEALTH HISTORY

Physician's Name_______________________________________________ Date of last visit ______________________

Please a mark on "Yes" or "No" to indicate if you have ( or have had in the past) any of the following:

| Condition | | Condition | | Condition | |
|---|---|---|---|---|---|
| AIDS/HIV | ☐Yes ☐No | Diabetes | ☐Yes ☐No | Pacemaker | ☐Yes ☐No |
| Anemia | ☐Yes ☐No | Epilepsy | ☐Yes ☐No | Psychiatric Care | ☐Yes ☐No |
| Arthritis, Rheumatism | ☐Yes ☐No | Excessive Gag Reflex | ☐Yes ☐No | Require additional head support | ☐Yes ☐No |
| Artificial Heart Valves | ☐Yes ☐No | Fainting or dizziness | ☐Yes ☐No | Rheumatic Fever | ☐Yes ☐No |
| Artificial Joints | ☐Yes ☐No | Glaucoma | ☐Yes ☐No | Sexually Transmitted Disease | ☐Yes ☐No |
| Asthma | ☐Yes ☐No | Headaches | ☐Yes ☐No | Shortness of Breath | ☐Yes ☐No |
| Back Problems | ☐Yes ☐No | Heart Disease/Murmur | ☐Yes ☐No | Sinus Trouble | ☐Yes ☐No |
| Bleeding abnormal | ☐Yes ☐No | Hepatitis | ☐Yes ☐No | Swollen Feet or Ankles | ☐Yes ☐No |
| Blood Thinning Medication | ☐Yes ☐No | Type __________ | | Swollen Neck Glands | ☐Yes ☐No |
| Breathing Problems | ☐Yes ☐No | High Blood Pressure | ☐Yes ☐No | Thyroid Problems | ☐Yes ☐No |
| Cancer | ☐Yes ☐No | Kidney Disease | ☐Yes ☐No | Tuberculosis | ☐Yes ☐No |
| Chemical Dependency | ☐Yes ☐No | Liver Disease | ☐Yes ☐No | Ulcer | ☐Yes ☐No |
| Chest Pain | ☐Yes ☐No | Mitral Valve Prolapse | ☐Yes ☐No | Weight Loss, unexplained | ☐Yes ☐No |
| Daytime Sleepiness | ☐Yes ☐No | Osteoporosis | ☐Yes ☐No | | |

Women: Taking birth control pills? ☐Yes ☐No Are you pregnant? ☐Yes ☐No Due date __________ Are you nursing? ☐Yes ☐No

Do you take or have you taken in the past **Bisphosphonates** for treatment of osteoporosis? ………………………………… ☐Yes ☐No

Do you have chest pain, shortness of breath, or get tired easily when you walk or when you walk up steps? ……………… ☐Yes ☐No

Do you ever wake up from sleep short of breath? ……………………………………………………………………………….. ☐Yes ☐No

Have you been admitted to the hospital or needed emergency care in the past two years? ……………………………….... ☐Yes ☐No

In your past dental visits, what has been your level of comfort? ***Very Relaxed* <** ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **> *Very Anxious***

In general, do you require local anesthetic for dental procedures? ☐ Always, Please ☐ Not for small stuff ☐ Almost never

### MEDICATIONS

List any medication you are currently taking and the correlating diagnosis:

1.____________________________ 4.__________________________

2.____________________________ 5.__________________________

3.____________________________ 6.__________________________

Pharmacy Name _____________________________________________

Pharmacy Phone # __________________________________________

### ALLERGIES

☐ Aspirin ☐ Local anesthetic

☐ Codeine ☐ Penicillin

☐ Erythromycin ☐ Sulfa

☐ Iodine

☐ Latex ☐ None

☐ Other _____________________________________________

_____________________________________________

### ACKNOWLEDGMENT

I have read and answered the above questions to the best of my knowledge.
I understand that the patient portion of dental services is estimated and due at the time of service. This amount may be subject to adjustment when the insurance company doesn't pay as estimated.
I understand that the office of Krasnodara Gashparova DDS provides insurance company billing as a *courtesy* to me.
I consent that I am financially responsible for all charges whether or not paid by the insurance.
I grant my permission to your office, to telephone me to discuss matters related to this form.
I understand that my insurance policy has a maximum dollar amount for dental services that can be reimbursed within each plan year.
I consent that I will be responsible for the full amount of dental services that exceed the particular plan's limitations.
I have read the above conditions of treatment and payment and agree to their content.

Patient (Legal Guardian) Signature ________________________________________ Date_______________________________

Doctor's Signature _____________________________________________________ Date _______________________________