Shakun Salomons & Bray
DENTAL P.C.

MINOR ADULT ACCOUNT INFORMATION

BIRTHDATE ________________ TODAY'S DATE ________________

NAME ________________ SEX ______ DRIVER'S LICENSE # ________________

LOCAL ADDRESS ________________ LOCAL PHONE # ________________

________________ CELL PHONE # ________________

BILLING ADDRESS ________________

E-MAIL ADDRESS ________________

FATHER ________________ BIRTHDATE ________________ SS # ________________

EMPLOYER ________________ ADDRESS ________________ WK. # ________________

MOTHER ________________ BIRTHDATE ________________ SS # ________________

EMPLOYER ________________ ADDRESS ________________ WK. # ________________

PERSON RESPONSIBLE FOR DENTAL INVESTMENT ________________

SOMEONE TO NOTIFY IN CASE OF EMERGENCY ________________

ADDRESS ________________ PHONE # ________________

WHOM MAY WE THANK FOR THIS REFERRAL? ________________

INSURANCE INFORMATION

PRIMARY

EMPLOYEE ________________

INSURANCE CO. ________________

ADDRESS ________________

____

GROUP # ________________

SUBSCRIBER ID # ________________

SECONDARY

EMPLOYEE ________________

INSURANCE CO. ________________

ADDRESS ________________

____

GROUP # ________________

IF INSURANCE THROUGH STEP-PARENT:

NAME ________________ SS # ________________

ADDRESS ________________

BIRTHDATE ________________ EMPLOYER ________________

FORM 166001 N/06/13 ITEM 8101

MEDICAL HISTORY

PLEASE CIRCLE THE APPROPRIATE RESPONSE. IF YOU DON'T KNOW THE CORRECT ANSWER, WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name . . . .

Address . . . .

2. Are you under a physician's care? . . . . **YES** **NO**

Since when? ______________ Why? ____

3. When was your last complete physical exam? ____
4. Are you taking any of the following medications:
   - a. Antibiotics . . . . **YES** **NO**
   - b. Anticoagulants (blood thinners) . . . . **YES** **NO**
   - c. Medicine for high blood pressure . . . . **YES** **NO**
   - d. Cortisone (steroids) . . . . **YES** **NO**
   - e. Tranquilizers . . . . **YES** **NO**
   - f. Antihistamines . . . . **YES** **NO**
   - g. Aspirin . . . . **YES** **NO**
   - h. Insulin, tolbutamide (Orinase) or similar drug . . . . **YES** **NO**
   - i. Digitalis or drugs for heart trouble . . . . **YES** **NO**
   - j. Nitroglycerin . . . . **YES** **NO**
   - k. Oral contraceptive or other hormonal therapy . . . . **YES** **NO**
   - l. Other (Please list all) . . . . **YES** **NO**
5. Do you have or have you been treated for any of the following:
   - a. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis) . . . . **YES** **NO**
   - b. Damaged heart valves or artificial heart valves . . . . **YES** **NO**
   - c. Stroke . . . . YES NO
   - d. High blood pressure . . . . **YES** **NO**
   - e. Heart murmur or mitral valve prolapse . . . . **YES** **NO**
   - f. Congenital heart lesions . . . . **YES** **NO**
   - g. Cardiac pacemaker . . . . **YES** **NO**
   - h. Fainting spells or seizures . . . . **YES** **NO**
   - i. Arthritis . . . . **YES** **NO**
   - j. Inflammatory rheumatism (painful swollen joints) . . . . **YES** **NO**
   - k. Hepatitis, jaundice or liver disease . . . . **YES** **NO**
   - l. Stomach ulcers or stomach problems . . . . **YES** **NO**
   - m. Kidney trouble . . . . **YES** **NO**
   - n. Tuberculosis . . . . **YES** **NO**
   - o. Do you have a persistent cough or cough up blood . . . . **YES** **NO**
   - p. Low blood pressure . . . . **YES** **NO**
   - q. Venereal disease . . . . **YES** **NO**
   - r. Epilepsy or seizure disorder . . . . **YES** **NO**
   - s. Psychiatric problems . . . . **YES** **NO**
   - t. Cancer . . . . **YES** **NO**
   - u. Rheumatic fever . . . . **YES** **NO**
   - v. Sinus trouble . . . . **YES** **NO**
   - w. Asthma or hay fever . . . . **YES** **NO**
   - x. Hives or skin rash . . . . **YES** **NO**
   - y. Diabetes . . . . **YES** **NO**
   - z. Spina Bifida . . . . **YES** **NO**
6. Have you ever had a serious illness, condition or major surgery not listed? . . . . **YES** **NO**

Explain: ____

7. Have you ever had surgery, chemo or radiation treatment for a tumor, growth or other condition? . . . . **YES** **NO**
8. Do you have any blood disorders such as anemia or leukemia? . . . . **YES** **NO**
9. Have you ever had a blood transfusion? . . . . **YES** **NO**
10. Do you have an artificial joint/prosthesis? . . . . **YES** **NO**

11. Have you tested HIV positive? . . . . YES NO
12. Are you allergic to, or sensitive to, any of the following:
    a. Local anesthetics . . . . YES NO
    b. Penicillin or other antibiotics . . . . YES NO
    c. Sulfa drugs . . . . YES NO
    d. Barbiturates, sedatives, or sleeping pills . . . . YES NO
    e. Aspirin . . . . YES NO
    f. Iodine . . . . YES NO
    g. Codeine or other narcotics . . . . YES NO
    h. Latex (rubber) . . . . YES NO
    i. Any metals or jewelry . . . . YES NO
    j. Other (please list) . . . . YES NO
    k. Bananas, avocados, chestnuts or kiwis . . . . YES NO
13. Do you smoke or chew tobacco? . . . . YES NO
14. Do you habitually consume alcoholic beverages? . . . . YES NO
15. Do you habitually use controlled substances? . . . . YES NO

WOMEN

16. Are you pregnant or suspect you might be? . . . . YES NO
17. Do you use any birth control medications? . . . . YES NO
18. Are you nursing? . . . . YES NO

DENTAL HISTORY

1. Purpose of this visit ______________________________

   ____
2. How long since your last visit? ______________________________
3. Have you lost any teeth or have any teeth been removed? . . . . YES NO
4. Have they been replaced? . . . . YES NO
5. Are you happy with the replacements? . . . . YES NO
6. Would you like to know more about permanent replacements? . . . . YES NO
7. Have you ever had any problems with previous dental treatment? . . . . YES NO
   If yes, explain: ______________________________
8. Do you clench or grind your teeth? . . . . YES NO
9. Does your jaw click or pop? . . . . YES NO
10. Do you have frequent headaches, neck or shoulder aches? . . . . YES NO
11. Do your gums bleed or hurt? . . . . YES NO
12. How often do you brush your teeth? ______________________________
13. Do you use dental floss? . . . . YES NO
14. Are you unhappy with the appearance of your teeth? . . . . YES NO
15. Do you feel your breath is offensive at times? . . . . YES NO
16. Have you ever had gum treatment or surgery? . . . . YES NO
17. Have you ever had any orthodontic work? . . . . YES NO
18. Do you have any questions or concerns? . . . . YES NO
19. Is there anything you wish to discuss with the Doctor privately? . . . . YES NO

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

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Signature of Parent / Guardian   Date