Roman Khodosh DDS P.C.

General Implant and Cosmetic Dentistry

Welcome to our practice. All information is completely confidential. Date_____

First_____ Middle_____ Last_____

How do you prefer to be called _____?

DOB_____ Age_____ Gender _____ SSN_____ single/married/divorced

Driver License Number _____

Home Address _____ City_____ State_____ Zip_____

Home Phone _____ Cell phone _____ Email _____

Are you currently in school? Yes NO School Name _____ Degree Pursuing _____

Occupation _____

Employed by _____

Business address_____

Business Phone _____

Email _____

Present Position _____

How long at the current position? _____

Spouse/Partner _____

Occupation _____

Employed by _____

Business address_____

Business Phone _____

Email _____

Present Position _____

How long at the current position? _____

Own a Business? Yes No Name of Business _____ Years in Business ___

Retired? Yes NO Years in retirement _____ Previous Occupation _____ For How long? __

Most of our patients come from Referrals from our valued patients.

Who may we Thank for referring you to us? _____ Your Relationship to the person _____

How did you hear about us if it's other than referral from friend or family member?

Live in building Saw the Sign Insurance recommendation Internet

If internet - What search engine? Google/ Yahoo/ other _____ What phrase did you search for?

(Ex. Dentist, Implant Dentist, Gentle Pain Free dentist) _____

Other Source _____

What Attracted you the most to come to us? _____

**** IMPORTANT * IMPORTANT * IMPORTANT ****

Please take a few minutes to go through each question carefully and thoroughly, giving it some thought. Your full participation and involvement in this will have a direct effect on your experience with us and more importantly long term outcome of your dental treatment and care. It will play a huge role in how happy and satisfied you will be with the results.

Remember we are here for you and we will do our best to help you get the best possible results for your particular situation, no matter how small or big your concerns are. However, we can not help you unless you help yourself 1st.

HELP US HELP YOU!

From 0 → 10

How would you rate your current:

State of Dental Health?_____

Smile Confidence? _____

Happiness and Satisfaction with Teeth Color? _____

Happiness and Satisfaction with Shape and Alignment of your Teeth? _____

1. What do you enjoy and like about your teeth and smile? Or if you're missing your teeth, what do you enjoy about your current replacement of your teeth? _____

_____

_____

2. What is YOUR ultimate goal for your Dental Health, Smile? _____

_____

_____

3. If you would accomplish your goals, what would that give you personally? How would it make you feel?

_____

_____

3a. What has stopped you in the past from achieving what you want? (Ex. Bad previous experience, lack of finances, fear of pain, other) _____

_____

3b. What is your greatest fear when it comes to dental treatments? _____

_____

4. What are your 3 most immediate problems/concerns/needs that we can help you solve? (List in order of importance)

1._____

2._____

3._____

What can we do for you?

Immediately _____

In 1 year time _____

In 3 years time _____

PATIENT MEDICAL HISTORY

PATIENT'S NAME: _____ TODAY'S DATE: _____

1 Do you or have you in the past taken any Bisphosphonares? Y/N _____

Ex: Actonel, Fosamax, Boniva or Others. Pills or IV Lenth of Time

2 Are you taking any Anticoagulants (Blood Thinners)?

Ex: Aspirin, Coumadin, Heporin or Others. Y/N

3 Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? Y/N

4 Have you ever had any surgeries or been hospitalized? Y/N

5 Have you ever needed to be pre-medicated for dental appointments? Y/N

6 Is there any disease, condition or problem that you think this office should know about that is not covered above? Y/N

If female please answer the following:

Y	N	
☐	☐	Are you talking Birth Control Pills?
☐	☐	Are you pregnant? If Yes. # of months _____
☐	☐	Are you nursing?

List current medications:

_____

_____

_____

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ Aids
☐	☐	Kidney Problem
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Asprin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicilin
☐	☐	Tetracycline

Other

_____

_____

_____

Signature: _____ Date: _____

(If under 18, Parents or Guardian Signature Required)

Dear Patients

PLEASE HELP US MAKE YOUR VISIT AS COMFORTABLE AS POSSIBLE

WE WILL SET UP THE ROOM WITH THE CUSTOM MUSIC OF YOUR CHOICE

PLEASE SELECT FROM PREFFERED LIST OF GENRES OF YOUR CHOICE AND CIRLE AND WRITE 1^{ST}, 2^{ND} CHOICE, AND WE WILL DO OUR BEST TO MATCH IT. You can also change your choice at a later time by mentioning to a doctor's assistant.

- Z 100
- FRESH 102.7
- ABSOLUTE SMOOTH JAZZ
- TOP 40 HIT STATION

- OLDIES (30'S , 40'S 50'S 60'S 70'S)
- DANCE
- EURO-DANCE
- R & B
- ROCK
- SOFT ROCK
- LATIN
- FRANK SINATRA AND THE LIKES

OTHER _____

**** YOU CAN ALSO USE OUR STATE OF THE ART 'NOISE CANCELLING HEADSETS' with your I-pod, CD or Mp3 players.

NO MUSIC DURING MY VISITS

Patient's Name _____