JOHN W. DOVGAN, D.D.S.,P.C.

3841 East Thunderbird Road, Suite 101
Phoenix, Arizona 85032
(602) 867-1899

PLEASE PRINT

PATIENT INFORMATION

NAME OF PATIENT_____ Mr, Mrs, Ms or Child

Street_____APT#_____ Home Phone_____
City_____ ZIP _____ Cell Phone_____
EMAIL _____ Work Phone_____

AGE OF PATIENT _____ BIRTH DATE _____ MALE FEMALE

IF UNDER 18 YEARS OLD OR
STUDENT NAME OF PARENTS_____ SOCIAL SECURITY #_____

BILLING INFORMATION

RESPONSIBLE PARTY_____

Street_____APT#_____ Home Phone_____
City_____ ZIP _____ Cell Phone_____

SOCIAL SECURITY #_____ BIRTH DATE _____ WK PH _____

EMPLOYED BY _____

EMAIL _____

INSURANCE INFORMATION

Insured Name _____ Birth date _____ SS#_____

Address _____APT#_____City_____State_____Zip_____

Insurance Company _____ID#_____Group _____

Insurance Co. Address_____Ph#_____

Employer Name_____

Is anyone in your family a patient here? Name_____Relationship_____

IN CASE OF EMERGENCY, NAME OF PERSON NOT LIVING WITH YOU

NAME_____ PHONE_____Relationship_____

NAME_____ PHONE_____Relationship_____

Interest of 1.5% per month or 18% APR is charged after 60 days and is based on the unpaid balance.

I authorize the release of treatment information and I hereby assign any insurance benefits to the doctor.

A COPY OF THIS OFFICE'S PRIVACY POLICY HAS BEEN MADE AVAILABLE.

SIGNATURE_____ DATE _____

Dental Information

For the following questions, please mark (X) your response to the following questions.

	Yes	No
Do your gums bleed when you brush or floss	☐	☐
Are your teeth sensitive to cold,hot sweets or pressure?	☐	☐
Does food or floss catch between teeth.....	☐	☐
Is your mouth dry?.....	☐	☐
Have you had any periodontal (gum) treatments?.....	☐	☐
Have you ever had orthodontic (braces) treatment?.....	☐	☐
Have you had any problems associated with previous dental treatment?.....	☐	☐
Is your home water supply fluoridated?.....	☐	☐
Do you drink bottled or filtered water?.....	☐	☐
If yes, how often? DAILY WEEKLY OCCASIONALLY		
Are you currently experiencing dental pain or discomfort?.	☐	☐

What is the reason for your dental visit today? _____

	Yes	No
Do you have earaches or neck pains?.....	☐	☐
Do you have any clicking, popping or discomfort in the jaw?.	☐	☐
Do you brux or grind your teeth?.....	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?.....	☐	☐
Do you participate in active recreational activities?....	☐	☐
Have you ever had a serious injury to your head or mouth?...	☐	☐

Date of your last dental exam _____

What was done at the time?: _____

Date of last dental X rays: _____

How do you feel about your smile? _____

Medical Information

Please mark(x) your response to indicate if you have or have not had any of the following diseases or problems.

Do you have any of the following diseases or problems?:	Yes	No
Active tuberculosis.....	☐	☐
Persistent cough greater than a 3 week duration.....	☐	☐
Cough that produces blood.....	☐	☐
Been exposed to anyone with tuberculosis.....	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

	Yes	No
Are you now under the care of a physician.....	☐	☐
Are you in good health?.....	☐	☐
Has there been any change in your general health within the past year?.....	☐	☐

Physician Name: _____

Phone: include area code _____

Address/City/State/Zip: _____

Date of last physical exam: _____

If yes, what condition is being treated? _____

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	☐	☐
If yes, what was the illness or problem?		
Are you taking or have you recently taken any prescription or over the counter medicines?.....	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.

Local anesthetics.....	☐	☐	Iodine.....	☐	☐
Aspirin.....	☐	☐	Hay fever/seasonal.....	☐	☐
Penicillin or other antibiotics.....	☐	☐	Animals.....	☐	☐
Barbiturates, sedatives or sleeping pills.....	☐	☐	Food.....	☐	☐
Sulfa drugs.....	☐	☐	Metals/Latex (rubber).....	☐	☐
			Other.....	☐	☐

Joint Replacement- Have you had an orthopedic total joint (hip, knee, elbow, finger replacement?..... ☐ ☐

Date: _____ If yes, have you had any complications? _____

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..... ☐ ☐

Date Treatment began: _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?..... ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.... ☐ ☐

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition or problem not listed above that you think I should know about?

Please explain: _____

_____

Medical Information (Continued)

	Yes	No
Do you use controlled substances	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED	☐	☐
Do you drink alcoholic beverages?	☐	☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

Do you wear contact lenses?	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic Lupus Erythematosus	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder	☐	☐
Malnutrition	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart values	☐	☐
Heart Attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
Other congenital heart defects	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic Fever	☐	☐
Rheumatic heart disease	☐	☐

Iodine or other narcotics	☐	☐
Tumor, growth or other condition?	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
If yes, date:		
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Neurological disorders	☐	☐
If yes, specify	☐	☐
Sleep disorder	☐	☐
Mental health disorders		
Specify:		
Recurring infections	☐	☐
Type of infections:		
Kidney problems	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands	☐	☐
in neck	☐	☐
Severe headaches/ Migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
Excessive urination	☐	☐
Artificial (Prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)	☐	☐
Unrepaired, cyanotic (CHD)	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defeats	☐	☐

Except for the conditions listed above. antibiotic prophylaxis is no longer recommended for any other form of CHD.

WOMEN ONLY Are you:		
Pregnant?	☐	☐
Number of weeks:		
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient./Legal Guardian: _____ Date: _____

Doctor's Signature: _____ Date: _____