Dr. Maemie Chan
Dr. David Hudec Jr.
Dr. Anthony LoPresti
Dr. John Shuster

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440-461-5482
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PATIENT INFORMATION

Patient Name ______________________ Nickname ______________________

Sex ☐ M ☐ F Birthdate ______________________ ☐ Single ☐ Married ☐ Other ____________

Address ______________________ City ____________ State ____________ Zip ____________

Employer ______________________ Position ______________________

Business Address ______________________

Whom may we thank for referring you? ______________________

Home Phone ______________________ Cell Phone ______________________

Work Phone ______________________ Email Address ______________________

How would you like your appointments confirmed? ☐ Home ☐ Work ☐ Cell ☐ Email

In case of an emergency, who should be notified? ______________________ Phone ____________

PRIMARY DENTAL INSURANCE

Person Responsible for Account ______________________

Relation to Patient ______________________ Birthdate ____________ Soc Sec # ____________

Primary Insurance Company ______________________ Group # ____________

Insurance Company Phone Number ______________________ Insurance ID # ____________

SECONDARY DENTAL INSURANCE

Person Responsible for Account ______________________

Relation to Patient ______________________ Birthdate ____________ Soc Sec # ____________

Secondary Insurance Company ______________________ Group # ____________

Insurance Company Phone Number ______________________ Insurance ID # ____________

DENTAL HISTORY

Reason for Today's Visit ______________________

Former Dentist ______________________ City / State ______________________

Check if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

MEDICAL HISTORY

Physician's Name ______________________ Date of Last Visit ______________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ______________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting / Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe ______________
- ☐ Hepatitis
  Type ______________
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemarker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tabacco Habit
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Premedicate

MEDICATIONS

Please list any medications you are currently taking:

____

____

ALLERGIES

Check if you are allergic to or have had a reaction to the following:

- ☐ Local anesthetics (Novocain)
- ☐ Penicillin or other antibiotics, please list ______________
- ☐ Latex
- ☐ Codeine or other narcotics, please list ______________
- ☐ Sulfa
- ☐ Other ______________

AUTHORIZATION

- I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise pauable to me for services rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment benefits.
- I understand that I am financially resposible for all charges whether or not paid by insurance.
- I authorize that all information provided is accurate.
- I authorize my consent for dental services.

Signature ______________________ **Date** ______________