PRISTINE DENTAL

Dr. Charles R. Verbanic D.D.S
127 Churchill Hubbard Rd, Youngstown, OH, 44505
(330) 759-4550

PERSONAL INFORMATION

Referred By: _____ E-mail: _____

Patient name: _____ Gender: ◯ Male ◯ Female DOB: _____

Social Security Number: _____ Address: _____

Home phone: _____ Cell phone: _____

Place of employment: _____ Occupation: _____

Spouse: _____ DOB: _____ Spouse place of employment: _____ Spouse SSN #: _____

Method of payment: ☐ Cash ☐ Credit Card ☐ Insurance

Insurance Company: _____ ID or SS#: _____

Subscriber name: _____

Secondary insurance: _____ ID OR SS#: _____

Physician name and number: _____ Number: _____

Emergency contact name: _____ Number: _____

DO YOU STILL HAVE YOUR TONSILS AND ADENOIDS YES NO

Do you snore: ..... ◯ Yes ◯ No Are you sleepy during the day ..... ◯ Yes ◯ No

Have you been diagnosed with sleep apnea: ..... ◯ Yes ◯ No

If so, do you use a CPAP: ..... ◯ Yes ◯ No

Do you currently use tobacco: ..... ◯ Yes ◯ No

If so what kind : _____

Have you had trouble with previous dental treatment: _____

Are you pregnant: ..... ◯ Yes ◯ No

CIRCLE ANY ILLNESSES THAT YOU HAVE OR HAVE HAD

- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Pacemaker
- ○ Hay Fever
- ○ Respiratory Problems
- ○ Fainting Spells
- ○ Asthma
  If so, what triggers attacks
  _____
- ○ Siezures or Epilepsy
  If so, when was last Siezures
  _____
- ○ Hepatitis
  Type
  _____
- ○ Diabetes
- ○ AIDS or HIV Infection
- ○ Thyroid Problems
- ○ Tuberculosis
- ○ Abnormal Bleeding
- ○ Bisphosphonates or Bone building medicine

○ Artificial Joints. If so date of surgery: _____

If receiving cancer treatment type and when diagnosed : _____

Date of last treatment and type: _____

Heart attack date: _____ Stroke date: _____

Please list all medications:

_____

Allergies: _____

FOR THE FOLLOWING QUESTIONS CIRCLE YES OR NO

Has there been any change in your general health within the past year ..... ○ Yes ○ No

Are you under the care of a physician ..... ○ Yes ○ No

If yes, what condition are you being treated for? _____

Have you ever had any serious illness, surgery or have been hospitalized in the last 2 years ..... ○ Yes ○ No

If yes, explain _____

Have you ever had heart surgery, an artificial heart valve, or bacterial endocarditis ..... ○ Yes ○ No

If yes, explain _____

Patient's Signature: _____ Date: _____