Ura

STEPHEN C. URA, D.D.S., P.A.

NEW PATIENT INFORMATION

MEDICAL HISTORY

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who is your physician? Dr. _____

Address _____ Phone _____

Do you have or have you ever had any major medical problem? ☐ Yes ☐ No

Have you been hospitalized ? ☐ Yes ☐ No

Are you now or have you recently been taking any drug or medication? ☐ Yes ☐ No

If yes, please list: _____

Are you allergic or sensitive to any drugs or medicine (e.g. penicillin, aspirin) ☐ Yes ☐ No

Do you have any difficulty with bleeding or healing from a cut wound or extraction? ☐ Yes ☐ No

WOMEN Are you: ☐ Pregnant ☐ Nursing ☐ Taking birth control pills
(Circle One)

Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	Allergies	☐	☐	Liver Disease	☐	☐
Heart Murmur	☐	☐	Nervous Disorder	☐	☐	Thyroid Problems	☐	☐
Heart Disease	☐	☐	Fainting Spells	☐	☐	Sinus Problems	☐	☐
Angina or Chest Pain	☐	☐	Diabetes	☐	☐	Skin Disease	☐	☐
High Blood Pressure	☐	☐	Arthritis	☐	☐	Venereal Disease	☐	☐
Stroke	☐	☐	Cancer	☐	☐	Herpes	☐	☐
Heart Valve Surgery	☐	☐	Tumors or Growths	☐	☐	HIV Positive	☐	☐
Anemia or Blood Disease	☐	☐	Tuberculosis (TB)	☐	☐	A.I.D.S.	☐	☐
Lung Disease	☐	☐	Kidney Disease	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	Seizure Disorders	☐	☐	Glaucoma	☐	☐
Latex Allergy	☐	☐	Nickel/Metal Allergy	☐	☐	Hip/Joint Replaced	☐	☐
Hay Fever	☐	☐	Stomach/Intestinal	☐	☐	Chemotherapy	☐	☐

Do you have or have had any disease, condition or problem not listed? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all the questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor or hygienist or any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Doctor Notes: _____

_____

_____

_____

NEW PATIENT INFORMATION

PATIENT'S NAME (PLEASE PRINT)	SEX M F	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.	MARITAL STATUS S M W D SEP
STREET ADDRESS ☒ PERMANENT ☐ TEMPORARY	CITY, STATE, ZIP				HOME PHONE NO.
PATIENTS E-MAIL	CELL PHONE / PAGER			FAX#	
PATIENT'S EMPLOYER (IF STUDENT, NAME OF SCHOOL)	OCCUPATION (IF STUDENT ☐ FULL-TIME ☐ PART-TIME)		HOW LONG EMPLOYED?/ YEAR AT SCHOOL		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP				EXTENSION
SPOUSE'S NAME	SPOUSE'S SOCIAL SECURITY NO.		# OF CHILDREN / AGES		
SPOUSE'S EMPLOYER (IF STUDENT, NAME OF SCHOOL)	OCCUPATION (IF STUDENT ☐ FULL-TIME ☐ PART-TIME)		HOW LONG EMPLOYED?/ YEAR AT SCHOOL		BUSINESS PHONE NO.
CLOSE RELATIVE IN CASE OF EMERGENCY	RELATIONSHIP				HOME PHONE NO.
RELATIVES STREET ADDRESS	CITY, STATE, ZIP				

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE, ZIP	HOME PHONE NO.
MOTHER'S EMPLOYER	OCCUPATION	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP	EXTENSION
FATHER'S NAME	STREET ADDRESS, CITY, STATE, ZIP	HOME PHONE NO.
FATHER'S EMPLOYER	OCCUPATION	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP	EXTENSION

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY TREATMENT PERFORMED, WHETHER OR NOT I HAVE DENTAL INSURANCE.
FINANCE CHARGES AT 1 1/2% PER MONTH (18% APR) ON ACCOUNTS OVER 30 DAYS.

PLEASE SIGN _____ _____
SIGNATURE (PATIENT / GUARDIAN) DATE

INSURANCE INFORMATION: ***IF YOU WISH US TO PROCESS INSURANCE CLAIMS, THIS PORTION MUST BE COMPLETED.***

1st or PRIMARY INSURANCE CARRIER	2nd or SECONDARY INSURANCE CARRIER
EMPLOYER'S NAME	EMPLOYER'S NAME
EMPLOYEE/SUBSCRIBER NAME	EMPLOYEE/SUBSCRIBER NAME
SUBSCRIBER BIRTH DATE	SUBSCRIBER BIRTH DATE
EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.	EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.
PATIENT'S RELATIONSHIP TO EMPLOYEE/SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	PATIENT'S RELATIONSHIP TO EMPLOYEE/SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
INS. COMPANY NAME	INS. COMPANY NAME
ADDRESS	ADDRESS
GROUP PLAN #	GROUP PLAN #
SUBSCRIBER OR BADGE #	SUBSCRIBER OR BADGE #
DEDUCTIBLES ☐ Yes ☐ No $	DEDUCTIBLES ☐ Yes ☐ No $
MAXIMUM BENEFIT PER YEAR $	MAXIMUM BENEFIT PER YEAR $

I HEREBY AUTHORIZE RELEASE OF INFORMATION RELATING TO THE TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS
I HEREBY AUTHORIZE PAYMENT DIRECTION TO URA FAMILY DENTISTRY // STEPHEN C. URA, D.D.S., P.A.
OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____ _____ _____ _____
SIGNED (PATIENT / GUARDIAN) DATE SIGNED (INSURED PERSON) DATE

PATIENTS ARE EXPECTED TO MAKE PAYMENT WHEN SERVICES ARE RENDERED.

THE INVESTMENT NECESSARY TO COMPLETE DENTAL TREATMENT IS AN ESTIMATE BASED ON INFORMATION FROM OUR EXAMINATION. SHOULD ADDITIONAL PROBLEMS ARISE, AS TREATMENT PROGRESSES. THIS ESTIMATE MAY BE REVISED. THIS ESTIMATE WILL BE HONORED FOR A PERIOD OF THREE (3) MONTHS ONLY.

DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you get food caught between any teeth? _____ ☐ ☐

GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____