

Dr. Daniel P. Bitner - Dr. Patricia Paparcuri

**PATIENT INFORMATION**

**IN CASE OF EMERGENCY:**

Please circle: Ms. Mr. Mrs. Dr.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relative to contact other than spouse or parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your General Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY**

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized in the last 5 years? NO YES If YES, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications are you taking now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications are you sensitive or allergic to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an unusual/allergic reaction to: Latex NO YES Local Anesthetic NO YES

Have you ever had an unfavorable reaction to dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you required to take premedication antibiotics before dental treatment? No Yes

*For the following questions circle YES or NO. Your answers are for our records only and will be confidential. Please note that during your visit you may be asked some questions about your responses. Our team may ask additional questions concerning your health.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Heart Murmur (mitral valve) prolapse) | No | Yes | Kidney Disease | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Anemia | No | Yes | Liver Disease (including Jaundice) | No | Yes | Latex Sensitivity | No | Yes |
| Diabetes | No | Yes | Venereal Disease | No | Yes | Stroke If yes, when | No | Yes |
| Epilepsy | No | Yes | HIV Infection / AIDS | No | Yes | Stomach ulcers | No | Yes |
| Hepatitis, any form | No | Yes | Psychosis/Mental Disorder | No | Yes | Tuberculosis | No | Yes |
| Rheumatic Fever | No | Yes | Depression | No | Yes | Cancer – If yes, type tytytype\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | No | Yes |
| Infective Endocarditis | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes | Bruise easily | No | Yes |
| Asthma | No | Yes | Slow-Healing Mouth Sores | No | Yes | Dizzy | No | Yes |
| Hypertension / High Blood Pressure | No | Yes | Thyroid disease – Hyper or Hypo | No | Yes | Sinus infection | No | Yes |
| Emphysema / Respiratory Illnesses | No | Yes | Joint Replacement If Yes, when | No | Yes | Drug addiction | No | Yes |
| Abnormal Heart Condition | No | Yes | Glaucoma | No | Yes | Pain in jaw joint | No | Yes |
| Heart (surgery, disease, attack) | No | Yes | Abnormal bleeding from a cut | No | Yes | Fainting | No | Yes |

Any other disease or problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been on Bisphosphonate drug therapy used commonly for osteoporosis or cancer treatment? e.g. Fosamax, Alendronate, Actonel, Risedronate, Boniva, Zometa, Aredia or Novartis? YES NO

Are you a smoker? No Yes If so, how much do you smoke per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Do you take Aspirin? No Yes If Yes, what dose? \_\_\_\_\_\_\_\_\_ How often?\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any herbal supplements/medicines? No Yes If Yes, which ones?\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_

Diet: Restricted Diet \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many meals a day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sugar in your diet: ☐ None ☐ Slight ☐ Moderate ☐ High

Are you in dental pain at this time? Indicate level: 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain, 10 = severe pain)

*STATEMENT OF INFORMED CONSENT: I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all 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 of change in my health and medication. I consent to the performing of the procedures necessary to evaluate and diagnose my condition. I consent to the treatment as deemed necessary and advisable by Dr. Daniel Bitner / Dr. Patricia Paparcuri, including the administration of medication and anesthetics. I consent to the release of health care information between my treating practitioner and my insurance carriers. I acknowledge that I am financially responsible for all charges, whether these charges are covered by my insurance or not. If it becomes necessary to turn over to collections any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize my doctor to release information necessary to secure the payment of benefits.*

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Patient (Print Name) Signature Date

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