PATIENT INFORMATION
(Confidential)

TOBY KRAVITZ, DDS
303 South U.S. Route 5, Unit 4
Norwich, VT 05055
802-649-2630

Date ____________________ Age______

Name ______________________________ Birth Date ____________ Home Phone ______________

Soc. Security # ____

Address ______________________________ City ______________ State _____ Zip__________

Check Appropriate Box Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Patient's or Parent's Employer ______________________________ Work Phone ______________

Business Address ______________________________ City ______________ State_____ Zip __________

Spouse's or Parent's Name ______________________ Employer ______________________ Work Phone __________

If Patient is a Student, Name of School or College ______________________________ City __________ State ___ Year ____

Whom may we thank for referring you? ____

Person to Contact in Case of Emergency ______________________________________ Phone ______________

RESPONSIBLE PARTY

Name of Person Responsible for this Account __________________________ Relationship to patient ______________

Address ______________________ City ______________ State _____ Home Phone ______________

Driver's License # ____ Birth Date ______________

Employer ______________________ City ______________ State _____ Work Phone ______________

Is this person currently a patient in our office? Yes ☐ No ☐

DENTAL INSURANCE INFORMATION

Name of Insured ______________________________ Relationship to patient ______________________

Birth date of insured ______________________________ Social Security # ______________________

Name of Employer ____ Work Phone______________

Address of Employer ______________________ City ______________ State _____ Zip__________

Insurance Company______________________________ Group or Plan # ______________________

Insurance Co. Address ______________________ City ______________ State _____ Zip __________

Insurance Co. Phone ______________ How much is your deductible? ___________ Max yearly benefit__________

Do you have additional insurance? yes ☐ no ☐ (if yes, complete the following)

Name of Insured ______________________________ Relationship to patient ______________________

Birth date of insured ______________________________ Social Security #______________________

Name of Employer ____ Work Phone ______________

Address of Employer ______________________ City ______________ State _____ Zip __________

Insurance Company______________________________ Group or Plan # ______________________

Insurance Co. Address ______________________ City ______________ State _____ Zip __________

Insurance Co. Phone ______________ How much is your deductible? ___________ Max yearly benefit__________

AUTHORIZATION AND RELEASE

I certify that I have read and understand the information on this form to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient of parent if minor ____

OVER PLEASE

PATIENT MEDICAL HISTORY

Physician ______________________ Office Phone ______________ Date of last exam __________

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what are you taking? ______________		
Do you use tobacco?	☐	☐
If so, how much? ______________		
Any reaction to jewelry or metals?	☐	☐

Are you allergic to any of the following?	Yes	No
Local anesthetics (novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Latex	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other ______________		

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

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low blood sugar	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐

	Yes	No
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint replacement or implants	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually transmitted disease	☐	☐

	Yes	No
Chest pains	☐	☐
Easily winded	☐	☐
Stroke	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent weight loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Stomach Trouble/ulcer	☐	☐
Other ______________		

Women only:	Yes	No
Are you or do you think you are pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

PATIENT DENTAL HISTORY

Are you having any discomfort at this time? ________ If so, where? ______________

How long since you have been to a dentist? ______________ Did you have x-rays? ______________

What was done at the time? ______________________________

How often do you generally visit a dentist? ______________________________

Do you have any teeth missing? __________ Why? ______________________________

Have they been replaced? ______________________________

Are your teeth sensitive to heat? ________ Cold? ______ Sweets? ______

Do you usually have many cavities? ________

Have you had your teeth straightened? ______________ When? ______ Any Relapse? ______

How often to you brush you teeth? ____________ Do you use dental floss? __________ How often? __________

Do you have difficulty flossing? ______ Do your gums bleed? ________ Any areas that trap food? ____________

Have you had periodontal treatment? ______________________________

Are you aware of grinding or clenching your teeth? ________ Do you have pain around your ears? ______________

Frequent earaches? ______ Frequent headaches? ______ Do your jaws ever feel tired or ache? ______ Do they click or pop? ______

Do you have any apprehensions of having dentistry done? ______ If so why? ______________________

How do you feel about the appearance of your teeth?

____

Please add anything you feel is important.

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