Septimiu N Pastiu, DMD Sewell Dental Arts

ABOUT YOU  Name:   prefer to be called
ABOUT YOU
Name: [ ] Male [ ] Female [ ] Male [ ] Female [ ] Single [ ] Married [ ] Child [ ] Other Birth date:/ Age: S.S. #: Home Address: State Zip Home Phone: ( ) ext Cell: ( )
prefer to be called
] Single [ ] Married [ ] Child [ ] Other   Birth date:/
[ ] Single [ ] Married [ ] Child [ ] Other Birth date:/
City State Zip         Home Phone: ()          Work: ()          Cell: ()
City         StateZip           Home Phone: ()            Work: ()            Cell: ()
Home Phone: () Work: ()ext Cell: ()
Home Phone: () Work: ()ext Cell: ()
Work: () ext Cell: ()
Cell: ()
L-man Address.
Employer:
How long there? Occupation:
Employer's Address:
City Zip
PERSON RESPONSIBLE FOR ACCOUNT
[ ] Same as above Name:
Birth date:// Relation:
Billing Address:
Billing Address:  CityStateZip
Home Phone: () Work: ()
S.S. #:
Employer:
Employer: Occupation:
SPOUSE INFORMATION
[] Same as above Name:
Birth date://
Employer:

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# DENTAL INSURANCE INFORMATION

Insurance Co. Name:	Primary insurance		Dł	none: ( )
Insured's Social Security #: Insured's Employer:  Secondary Insurance Insurance Co. Name:	Insurance Co. Name:	- Immercial	od'e Name:	ione
Insured's Social Security #: Insured's Employer:  Secondary Insurance Insurance Co. Name:	Group/Policy #:	Insui	eu s manne.	
Insured's Employer:	Insured's Birth date:	//Relation:		<del></del>
Secondary Insurance   Insurance   Co. Name:	Insured's Social Secu	Inty #:		<del></del>
Insurance Co. Name:	Insured's Employer: _			
Insurance Co. Name:		_		
Insured's Social Security #: Insured's Employer:    MEDICAL HISTORY INFORMATION	Secondary Insurance	e	51	nono: ( )
Insured's Social Security #: Insured's Employer:    MEDICAL HISTORY INFORMATION	Insurance Co. Name:		- de Marsa	lone: ()
Insured's Social Security #: Insured's Employer:    MEDICAL HISTORY INFORMATION	Group/Policy #:	insur	ed's Name:	
MEDICAL HISTORY INFORMATION  Name of Physician: Phone: (	Insured's Birth date: _	// Relation:		
Name of Physician: Phone: (	Insured's Social Secu	ırity #:		
Name of Physician: Phone: (	Insured's Employer: _			
Name of Physician: Phone: (	_			011
Phone: ( ) Do you have or have ever had any of the following? Please check those that apply:  [ ] Allergies/Hay	•		· ·	
Phone: ( ) Do you have or have ever had any of the following? Please check those that apply:  [ ] Allergies/Hay	Name of Physician: _			
[ ]Allergies/Hay	Phone: ( )			
[ ]Allergies/Hay	Do you have or have	ever had any of the fo	llowing? Please che	ck those that apply:
Fever [ ] Anemia	[ ]Allergies/Hay	[] Diabetes	Heart Surgery*	[] Rheumatic Fever
Seizures  [] Angina  [] Excessive Thirst  [] High Blood Pressure  [] Sickle Cell Disease  [] Arthritis  [] Fainting or Dizziness  [] Artificial Joints *  [] Fever Blisters/Cold Sores  [] Artificial Heart  Valves *  [] Asthma  [] Glaucoma [] Heart Disorder  [] Mental Disorders  [] Tuberculosis  [] Cancer [] Heart Infection* [] Chemical Dependency  [] Heart Pace  [] Respiratory  [] Yellow Jaundice				
Seizures  [] Angina  [] Excessive Thirst  [] High Blood Pressure  [] Sickle Cell Disease  [] Arthritis  [] Fainting or Dizziness  [] Artificial Joints*  [] Fever Blisters/Cold Sores  [] Artificial Heart Valves*  [] Asthma  [] Glaucoma [] Heart Disorder (Congenital)*  [] Cancer [] Heart Infection* [] Radiation Treatment  [] Yellow Jaundice	I I Anemia	[] Epilepsy or	[] Hepatitis	[] Rheumatism
[ ] Angina	, <b>L</b>			
Pressure   Disease     Arthritis     Fainting or Dizziness     HIV*/AIDS     Sinus Problems     Sinus Problems     Sinus Problems     Stroke     Stroke     Surgical Shunt*     Surgical Shunt*   Surgical Shunt	[ ] Angina		[] High Blood	[ ] Sickle Cell
[ ] Arthritis	[ ]		1	
Dizziness  [ ] Artificial Joints * [ ] Fever Blisters/Cold Sores  [ ] Artificial Heart	T 1 Arthritis	[1 Fainting or		I 1 Sinus Problems
[ ] Artificial Joints *	f 1) action	Dizziness		
Blisters/Cold Sores  [ ] Artificial Heart	[ ] Artificial Joints *	[] Fever	11 Kidney Problem	s [1Stroke
[ ] Artificial Heart Valves * [ ] Frequent Cough [ ] Liver Problems [ ] Surgical Shunt*  [ ] Asthma [ ] Glaucoma [ ] Mental Disorders [ ] Thyroid Problems  [ ] Breathing [ ] Heart Disorder [ ] Mitral Valve [ ] Tuberculosis  Problems (Congenital)* Prolapse*  [ ] Cancer [ ] Heart Infection* [ ] Osteoporosis [ ] Ulcers  [ ] Chemical [ ] Heart Murmur* [ ] Radiation [ ] Venereal Disease  Dependency [ ] Heart Pace [ ] Respiratory [ ] Yellow Jaundice		,	[], ((4), (4), (4), (4), (4), (4), (4), (4	
Valves *  [] Asthma	L 1 Adificial Heart		I 11 iver Problems	L1 Surgical Shunt*
[] Asthma       [] Glaucoma       [] Mental Disorders       [] Thyroid Problems         [] Breathing       [] Heart Disorder       [] Mitral Valve       [] Tuberculosis         Problems       (Congenital)*       Prolapse*         [] Cancer       [] Heart Infection*       [] Osteoporosis       [] Ulcers         [] Chemical       [] Heart Murmur*       [] Radiation       [] Venereal Disease         Dependency       [] Heart Pace       [] Respiratory       [] Yellow Jaundice	[ ] Altinoidi i lodic	I I i reduciii oodgii	[ ] Liver i represide	11 ouigious orium
[ ] Breathing		I 1 Glaucoma	[ ] Mental Disorder	s [1 Thyroid Problems
Problems (Congenital)* Prolapse*  [ ] Cancer [ ] Heart Infection* [ ] Osteoporosis [ ] Ulcers  [ ] Chemical [ ] Heart Murmur* [ ] Radiation [ ] Venereal Disease  Dependency Treatment  [ ] Chemotherapy [ ] Heart Pace [ ] Respiratory [ ] Yellow Jaundice				
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Dependency Treatment  [ ] Chemotherapy [ ] Heart Pace [ ] Respiratory [ ] Yellow Jaundice				
[ ] Chemotherapy [ ] Heart Pace [ ] Respiratory [ ] Yellow Jaundice		[ ] Heart Murmur*	,	[] venereal Disease
Maker* Problems	[ ] Chemotherapy	,		[] Yellow Jaundice
		Maker*	Problems	

<sup>\*</sup> This condition may require antibiotic premedication for certain dental procedures.

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□ □ Do you have any health problems that were not listed above or need further clarifications?  If yes, explain: □ □ Are you now under the care of a physician? If yes, explain: □ □ Have you been admitted to a hospital or needed emergency care during the past two years? If yes, explain: □ □ Are you taking any medications or herbals? If yes, list: □ □ Are you allergic to any medications or substances? If yes, please check box below: □ □ Are you used tobacco? If yes, please check box below: □ □ Have you used tobacco? If yes, explain: □ □ Have you used tobacco? If yes, explain: □ □ Have you find you used tobacco? If yes, explain: □ □ Have you find you seed tobacco? □ □ Hav	YES N	
If yes, explain:		Do you have any health problems that were not listed above or need further
Are you now under the care of a physician?  If yes, explain:  Have you been admitted to a hospital or needed emergency care during the past two years?  If yes, explain:  Are you taking any medications or herbals?  If yes, list:  Are you allergic to any medications or substances?  If yes, please check box below:  [] Aspirin [] Penicitlin [] Codeine [] Iodine [] Metal [] Latex [] Other  Have you used tobacco?  If yes, explain:  WOMEN (Please check): [] Pregnant [] Trying to get pregnant [] Nursing [] Taking oral contraceptives  To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.  X	clarific	
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I have read my MEDICAL HISTORY dated and confirm that it states past and present conditions.  Date: Exceptions: Patient's Signature:  [] None x	To the	e best of my knowledge, all of the preceding answers are correct. If I have any changes in
I have read my MEDICAL HISTORY dated and confirm that it states past and present conditions.  Date: Exceptions: Patient's Signature:  [] None x	~	
I have read my MEDICAL HISTORY dated and confirm that it states past and present conditions.  Date: Exceptions: Patient's Signature:  [] None x	Signa	ture of patient, parent or guardian
Date: Exceptions: Patient's Signature:  [] None x		MEDICAL UPDATES
[] None x	l hav past	e read my MEDICAL HISTORY dated and confirm that it states and present conditions.
	Date	: Exceptions: Patient's Signature:
[] None x		[] None x
		[] None x
[] None x		[] None x

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## DENTAL HEALTH QUESTIONNAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan. We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern. Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there. We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together.

Please help us better understand your dental health needs and goals by answering the following questions. (check the best answer):

- 1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years? [] Yes [] No
- 2. I have a [] low [] moderate [] high fear of going to the dentist.
- 3. My mouth and teeth are [] very [] moderately [] not comfortable.
- 4. I am [] very satisfied [] satisfied [] dissatisfied with the appearance of my teeth.
- 5. I think my present state of dental health is [] excellent [] good [] fair [] poor.
- 6. I would say that my main concerns with my dental health are:
- 7. I am interested in a smile evaluation and personalized treatment plan to enhance my smile. [] Yes [] No
- 8. Please check which statement below best represents the level of dental health you wish to achieve. (Some people begin at one level and progress to a higher level over time.)

#### [] HEALTH LEVEL I - Emergency Care

I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment. I am not very interested in thinking about the future of my teeth at this time.

## [] HEALTH LEVEL II - Maintenance Care

I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

#### [ ] HEALTH LEVEL III - Comprehensive Care

I am interested in comprehensive care to achieve and maintain a higher level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

## [ ] HEALTH LEVEL IV - Comprehensive & Cosmetic Care

I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health. I am concerned about treating the causes of dental diseases, not simply the effects. I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and

esthetics, so as to achieve long-term stable, yet esthetic, dental health.