Welcome to the office of

8340 Cleveland Avenue
N. Canton, Ohio 44720
330.494.6305

www.NorthCantonSmiles.com

Date:_____

PERSONAL INFORMATION (Please Print Legibly)

Last Name: _____ First Name: _____
Middle Initial: _____ SS #: _____
I would prefer to be called _____ by Dr. Bertolini and his team.
Address: _____
City: _____ State: _____ Zip: _____
Telephone - **Home**: _____ **Work**:_____
Cell: _____ **e-mail**:_____
Birth date: _____ Gender: M / F Marital Status: Single / Married / Divorced / Widowed
Occupation: _____
Whom may we thank for referring you?_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship:_____
Birth Date:_____ SS#:_____
Address: _____
City: _____ State: _____ Zip: _____
Telephone - **Home**: _____ **Work**:_____
Employer:_____ Employer Address:_____

DENTAL INSURANCE INFORMATION

Primary Insurance Co.:_____
Insurance Co. Address: _____
Group #: _____ I.D. #: _____

Secondary Insurance Co.:_____
Insurance Co. Address: _____

EMERGENCY CONTACT INFORMATION

In case of an EMERGENCY, who should we call? Name: _____

Telephone - Home: _____ Work:_____

Office Policy

1. Payment is requested for office procedure and office visits at the time the services are rendered unless other financial arrangements have been pre-arranged.
2. We will be glad to assist you with insurance billing. In order to submit your claim we must have authorization to release information to your insurance carrier. Your insurance carrier may or may not pay for the entire procedure. I agree to accept responsibility for all charges regardless of insurance coverage.
3. I have read the above policy carefully. I understand it and any questions I may have had have been answered to my satisfaction.

SIGNATURE: _____ ***DATE:***_____
Patient, parent or guardian

HEALTH INFORMATION

Patient Name: _____

Personal Physician Name & Address:_____

_____

Date of last physical examination: _____

Are you taking any medications? ____Yes ____No **If yes, please list all medications & dosages on back of this page or give any staff member a list to copy for your file.**

Have you had a serious medical problem or been hospitalized within the past 2 years? ____Yes ____No
Have you been under the care of a physician during the past 2 years? ____Yes ____No
Have you ever had any excessive bleeding requiring special treatment? ____Yes ____No
Have you taken any medicine or drugs in the past 2 years? ____Yes ____No
Are you allergic to or made sick by penicillin, aspirin, codeine, or any drugs or medications? ____Yes ____No
When you walk up stairs or take a short walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ____Yes ____No
Do your ankles swell during the day? ____Yes ____No
Do you use more than 2 pillows to sleep? ____Yes ____No
Have you lost or gained more than 10 pounds in the past year? ____Yes ____No
Do you ever wake up from sleep short of breath? ____Yes ____No
Are you on a special diet? ____Yes ____No
Has your medical doctor ever said you have cancer or a tumor? ____Yes ____No

For women only:

Are you pregnant now? ____Yes ____No Do you anticipate becoming pregnant? ____Yes ____No
Are you taking birth control? ____Yes ____No

Have you experienced the following?

Heart conditions

Mitral valve prolapse w/ regurgitation? ___Yes ____No
Prosthetic Heart valve? ___Yes ____No
Pacemaker? ___Yes ____No
High blood pressure? ___Yes ____No
Heart disease or attack? ___Yes ____No
Stroke? When?_____ ___Yes ____No
Aspirin taken regularly? ___Yes ____No

Eye Diseases? ___Yes ____No
Blurred vision? ___Yes ____No
Sinus Problems? ___Yes ____No
Ringing in ears? ___Yes ____No
Dry mouth? ___Yes ____No
Persistent cough? ___Yes ____No
Difficulty swallowing? ___Yes ____No

Joints

TM Joint pain? ___Yes ____No
Arthritis, Rheumatism? ___Yes ____No
Artificial joints? ___Yes ____No

Seizures? ___Yes ____No
Headaches? ___Yes ____No
Fainting spells? ___Yes ____No
Psychiatric care? ___Yes ____No

Stomach problems? ___Yes ____No
Frequent vomiting, nausea? ___Yes ____No
Excessive thirst? ___Yes ____No
Kidney or bladder disease? ___Yes ____No
Frequent urination? ___Yes ____No
Difficulty urinating? ___Yes ____No
Diarrhea, Blood stools? ___Yes ____No

Chronic

Rheumatic fever? ___Yes ____No
Emphysema? ___Yes ____No
Thyroid disease? ___Yes ____No
Diabetes? ___Yes ____No
Other?_____

Infectious disease

TB ___Yes ____No
AIDS or ARC? ___Yes ____No
VD (Syphilis, Gonorrhea)? ___Yes ____No
HPV (Human Papillomavirus)? ___Yes ____No
Herpes? ___Yes ____No
Hepatitis? A, B, or C? ___Yes ____No
Jaundice? ___Yes ____No

Do you have any disease, allergy or condition not listed here?_____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or medications I will inform the doctor at my next appointment.

SIGNATURE: _____ ***DATE:***_____

Patient, parent or guardian

DENTAL HISTORY

You deserve to achieve the level of health and comfort you desire.
We need all this information to do so predictably. We know we are asking for a lot of information and we appreciate your time in completing these very important forms. We prefer to treat friends and the best way to do this is to get to know you and your needs very well.

____Yes ____No Have you ever had a bad experience in the dental office?
____Yes ____No Are you in any discomfort at this time?
____Yes ____No Have you lost any teeth?
Why?_____
____Yes ____No Any complications with extractions? What?_____-
_____
Have they ever been replaced by:
a fixed bridge / a removable partial / a denture? (circle those applicable)
____Yes ____No Are your teeth sensitive to heat?
____Yes ____No to cold?
____Yes ____No to sweets?
____Yes ____No to sour?
____Yes ____No Do you have dry mouth?
____Yes ____No Have you had your teeth straightened? When?_____k-
_____
How often do you brush your teeth?_____ When?_____
How?_____
How long do you use a toothbrush before replacing it?_____
____Yes ____No Do you floss?
How often?_____
____Yes ____No Do you use a between the teeth stimulator or water jet?
____Yes ____No Do your gums bleed?
When?_____
____Yes ____No Do you eat between meals?
____Yes ____No Do you brush after snacks?
____Yes ____No Are you drinking fluids frequently?
How many glasses a day?_____
____Yes ____No Does food wedge between your teeth?
Where?_____
____Yes ____No Do you grind or clench your teeth?
When?_____
____Yes ____No Have you ever had gum (periodontal) treatments?
When?_____
____Yes ____No Do you feel you have bad breath at times?
____Yes ____No Unpleasant taste in your mouth?
____Yes ____No Any pain around your ears?
____Yes ____No Do your ears feel blocked?
____Yes ____No Do you snore?

____Yes ____No Do you have a nasal obstruction?

____Yes ____No Do you hear popping, clicking, or snapping noises when you chew?

____Yes ____No Are you aware of any swelling or lump in your mouth?

How long has it been since you have been to the dentist?_____

What was done then?_____

____Yes ____No Did you have x-rays?

How often did you visit a dentist before then?_____

Many patients consult with us for another opinion:

____Yes ____No Have you seen another dentist for your dental needs?

If yes, please explain._____

_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation.

0 - would **never** doze
1 - slight chance of dozing
2 - moderate chance of dozing
3 - high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	____
Watching TV	____
Sitting, inactive in a public place such as a theater or a meeting	____
As a passenger in a car for an hour without a break	____
Lying down to rest in the afternoon when circumstances permit	____
Sitting and talking to someone	____
Sitting quietly after lunch without alcohol	____
In a car, while stopped for a few minutes in traffic	____
Total score - add all responses	____

DON'T WAIT TILL IT HURTS...

Periodontal disease is painless. It affects 87% of the population and often victims are unaware. There are warnings signs, which the American Dental Association and our staff would like you to be aware.

Do your gums bleed when you brush your teeth or toothpick between them?	____Yes	____No
Are your gums red, swollen or tender?	____Yes	____No
Are your gums pulling away from your teeth?	____Yes	____No
Do you see pus between your teeth and your gums when gums are pressed?	____Yes	____No
Are your permanent teeth loose or separating?	____Yes	____No
Is there any change in the way your teeth fit together when you bite?	____Yes	____No
Is there any change in the fit if your partial dentures?	____Yes	____No

If the answer is yes to any of these questions, you owe it to yourself to bring it to the attention of your dentist or hygienist. Act now and keep your teeth for a lifetime!

SMILE EVALUATION

A few questions to help you obtain the smile you've always wanted!

Are your teeth Chipped / Protruding / Hidden?

Are you teeth all in alignment (straight)?	____Yes	____No
If not, explain._____		
Do you have spaces that you don't like?	____Yes	____No
If yes, explain._____		
Do you like the color of your teeth?	____Yes	____No
If not, explain._____		
If you could safely whiten your teeth, would you be interested?	____Yes	____No
Do you like the shape of your teeth?	____Yes	____No
If not, explain._____		
Are there old fillings or dental work that show when you smile or you don't like looking at?	____Yes	____No
If yes, explain._____		
Do you clench or grind you teeth?	____Yes	____No
If yes, explain._____		

What would you like to change the most about the appearance of your teeth?

_____

_____

_____

_____