Dr. Jacob Berger, D.D.S.

Family and Cosmetic Dentistry

Fill this form before printing, then sign the hard copy. Print

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss _____

Date of Last Dental Visit _____ How Often Do You Brush _____

***Please check all that apply*:**

Bad Breath ☐	Loose Teeth or Broken Fillings ☐	Sensitivity to Sweets ☐
Bleeding Gums ☐	Orthodontic Treatment ☐	Sensitivity When Biting ☐
Blisters on Lips or Mouth ☐	Pain Around Ear ☐	Frequent Headaches ☐
Finger Nail Biting ☐	Periodontal Treatment ☐	Jaw, Head, or Neck Injuries ☐
Grinding Teeth ☐	Sensitivity to Cold ☐	Jaw Difficulty: Clicking and/or Pain ☐
Lip or Cheek Biting ☐	Sensitivity to Heat ☐	Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medications?	☐	☐

Please describe:

_____

_____

4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reaction to the following:

	Yes	No
Local Anesthetics (e.g. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

Aids ☐	Emphysema ☐	Pacemaker ☐
Anemia ☐	Epilepsy ☐	Psychiatric Care ☐
Arthritis ☐	Fainting or Dizziness ☐	Radiation Treatment ☐
Anemia, Rheumatism ☐	Glaucoma ☐	Respiratory Disease ☐
Artificial Heart Valves ☐	Headaches ☐	Rheumatic Fever ☐
Artificial Joints ☐	Heart Murmur ☐	Scarlet Fever ☐
Asthma ☐	Heart Problems ☐	Shortness of Breath ☐
Back Problems ☐	Hepatitis-Type_____ ☐	Sinus Trouble ☐
Bleeding abnormally, with extractions or surgery ☐	Herpes ☐	Skin Rash ☐
Blood Disease ☐	High Blood Pressure ☐	Stroke ☐
Cancer ☐	HIV Positive ☐	Swelling of Feet/Ankles ☐
Chemical Dependency ☐	Jaundice ☐	Swollen Neck Glands ☐
Chemotherapy ☐	Jaw Pain ☐	Thyroid Problems ☐
Chronic Fatigue Syndrome ☐	Latex Sensitivity ☐	Tonsillitis ☐
Circulatory Problems ☐	Kidney Disease ☐	Tuberculosis ☐
Congenital Heart Lesions ☐	Liver Disease ☐	Tumor or growth on head/neck ☐
Cortisone Treatments ☐	Low Blood Pressure ☐	Ulcer ☐
Cough – persistent or bloody ☐	Mitral Valve Prolapse ☐	Venereal Disease ☐
Diabetes ☐	Nervous Problems ☐	

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Jacob Berger for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or of my dependents.

I authorize Dr. Jacob Berger and/or any provider or supplier of services in his office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____Date_____