PETER G. NOPOULOS DDS PC

880 13th Street
Marion, Iowa 52302

PERSONAL HISTORY

NAME _____ DATE _____

SPOUSE or PARENT _____

ADDRESS _____
STREET CITY, STATE ZIP CODE

BIRTHDATE _____ SS# _____

OCCUPATION _____ EMPLOYER _____

PRIMARY DENTAL INSURANCE: _____

EMPLOYER: _____

INSURED'S NAME: _____

INSURED'S SS#: _____ DATE OF BIRTH: _____

SECONDARY DENTAL INSURANCE: _____

EMPLOYER: _____

INSURED'S NAME: _____

INSURED'S SS#: _____ DATE OF BIRTH: _____

HOME PHONE: _____

BUSINESS PHONE: _____

CELLULAR PHONE: _____

Where should we call you during the day (8am – 5pm) to confirm your dental appointments? We prefer to speak directly with the patient.

HOME: _____ WORK: _____ CELLULAR: _____
(Please check one)

DENTAL HISTORY

PATIENT NAME: _____

What is the reason for your visit today?

_____

_____

Date of Last Dental Visit: _____
Last Dental Cleaning: _____
Last Full Mouth X-Rays: _____
What was done at your last dental visit? _____
Previous Dentist's Name: _____ Phone: _____

How often do you have dental examinations? _____

Are your teeth sensitive to hot/cold, sweets, biting or chewing? (please circle all that apply)

Do your gums bleed or hurt?	YES	NO
Have your parents experienced gum disease or tooth loss?	YES	NO
Have you noticed any loose teeth or change in your bite?	YES	NO
Does food tend to become caught in between your teeth?	YES	NO
If yes, where? _____		
Do you:		
Clench or grind your teeth while awake or asleep?	YES	NO
Often wake up with a headache?	YES	NO
Have tired or sore jaws, especially in the morning?	YES	NO
Smoke or chew tobacco?	YES	NO
Have you ever had:		
Periodontal treatment?	YES	NO
Your teeth ground or the bite adjusted?	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to the mouth or head?	YES	NO
If so, please describe, including cause: _____		
_____		
Have you experienced:		
Clicking or popping of the jaw?	YES	NO
Pain? (joint, ear, side of face)	YES	NO
Difficulty in opening or closing the mouth?	YES	NO
Headaches, neckaches or shoulder aches?	YES	NO
Sore muscles (neck, shoulders)?	YES	NO
Are you satisfied with the appearance of your teeth?	YES	NO
Do you feel nervous about having dental treatment?	YES	NO
If so, what is your biggest concern?_____		
_____		
Have you ever had an upsetting dental experience?	YES	NO
If yes, please describe: _____		
_____		

MEDICAL HISTORY

PATIENT NAME:_____

Have you been under the care of a medical doctor during the past two years? YES NO
If yes, for what? _____
Physician's Name:_____ Phone: _____
Address: _____
Have you taken any medication or drugs the past two years? YES NO
Are you taking any medication, drug or herbal medications now? YES NO
If yes, please list name and dosage: _____
Have you ever taken prescription medications for weight loss(diet pills)? YES NO
If yes, did you take any of the following:

Fen-Phen (Fenfluramine-Phenopermine)	YES	NO
Pondimen(Fenfluramine)	YES	NO
Redux (Dexfenfluramine)	YES	NO

If yes to any of the above, did you have a medical exam for heart issues? YES NO
Are you aware of having an allergic reaction to any medication or substance? YES NO
If yes, please list: _____
Have you been a patient in the hospital during the past five years? YES NO

Indicate which of the following you have had, or have at present. Circle 'yes' or 'no'

Heart(surgery,disease,attack)	Yes	No	Ulcers	Yes	No	Hepatitis A or B	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Stroke	Yes	No	AIDS	Yes	No	HIV Positive	Yes	No
Congenital Heart Defect	Yes	No	Emphysema	Yes	No	Cold Sores/Fever Blisters	Yes	No
Heart Murmur	Yes	No	Chronic Cough	Yes	No	Blood Transfusion	Yes	No
High Blood Pressure	Yes	No	Tuberculosis	Yes	No	Hemophilia	Yes	No
Mitral Valve Prolapse	Yes	No	Asthma	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Latex Sensitivity	Yes	No	Bruise easily	Yes	No
Heart Pacemaker	Yes	No	Drug Allergies	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Cancer	Yes	No	Yellow Jaundice	Yes	No
Cortisone/Steroids	Yes	No	Kidney Trouble	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Nervous,Anxious	Yes	No	Epilepsy or Seizures	Yes	No
Artificial Joints(hip, knee, etc)	Yes	No	Fainting or Dizzy Spells	Yes	No	Psychiatric Care	Yes	No
						Drug/ alcohol dependency	Yes	No

Do you use more than two pillows to sleep? Yes No
Have you or are you taking any medications (pills or IV) for osteoporosis? Yes No
Do you have or have you had any disease, condition, or problem not listed? Yes No
If yes, please list: _____

Women: Are you: Pregnant? Yes No If yes, how along?_____
Nursing? Yes No
Taking Birth Control Pills? Yes No

If you answered 'yes' to any of the above questions and you need more space to explain or tell us about your answer, please write the information on the lines below:

_____
_____
_____

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 any change in my health or condition.

Patient/Guardian Signature: _____ Date: _____

New Patient Referral

We welcome you as a new patient and are looking forward to taking care of your complete dental needs. Please help us by filling out this short questionnaire.

I was referred by:

A) Friend – (name of friend) _____

B) Yellow Pages

___ Yellow Book Phonebook (black and gold book cover) Has large photo of Dr. and staff

___ Quest Phonebook (yellow and white book cover)

C) Newcomer's Letter

___ letter you received from our office shortly after you moved to Marion.

D) Other – (short explanation) _____

_____

_____

Thank you for your valuable input,

Dr. Nopoulos and staff

Peter G. Nopoulos DDS P.C.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

PATIENT CONSENT FORM

By signing this form, you are granting consent to Peter G. Nopoulos DDS P.C. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our **Notice of Privacy Practices** provides more detailed information about how we may use and disclose this protected health information. You have the legal right to review our **Notice of Privacy Practices** before you sign this consent, and we encourage you to read it in full.

Our **Notice of Privacy Practices** is subject to change. If we change our notice, you may obtain a copy of the revised noticed by contacting Marion Family Dentistry at 319-373-1304.

You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we decide to grant your request, we are bound by our agreement.

You have a right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature _____

Date _____