Claremont Family Dentistry
Denys Andriyenko, DDS
2953 N Oxford St
Claremont, NC 28610

Date________________ Home Phone______________________________Cell Phone ____________________________________

Full Name_______________________________________ Sex ____M____F Age______ Date Of Birth______________________

Address______________________________________ City_________________ State_________ Zip___________

Marital Status: Married_____ Widowed_____ Single____ Minor____ Separated____ Divorced____ Partnered____

Patient Employer/School________________________________ Occupation_______________________________

Employer/School Address____ Work Phone___________________

Primary Insurance

Who is responsible for this account?_____________________ Relationship to Patient?___________________________

Insurance Co. ____ Group#____

Subscriber's Name: ______________________________________ Birthdate: _____________________________________

SSN: ____ Employer: ____

If the patient has additional insurance please notify someone at the front desk
****THE SOCIAL SECURITY NUMBER & DATE OF BIRTH OF THE POLICYHOLDER ARE REQUIRED ****

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to Dr. Andriyenko all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature/Relationship:____Date:______________________

Dental History

Reason for today's visit ____

Former Dentist ____ City/State ____

Date of last dental visit ____________________Date of last dental x-rays____________________

How often do you Brush?______________________ How often do you Floss?_________________

Health History

Physician's Name ____ Date of Last Visit ___________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These Include Combinations of Ionimin, Adipex, Fastin (brand names of phentermine, Pondimin (fenfluramine) and Redux(dexfenfluramine)
____Yes ____No

Have you ever taken any of the group of drugs collectively referred to as "bisphosphonates"? These include Fosamax, Zometa, Aredia, Actonel, and Skelid. ____Yes ____No

Do you have a history of bacterial endocarditis? ____Yes _____No *If yes, when were you diagnosed? ______________

Place an (X) on "Yes" or "No" to indicate if you have or had any of the following:

AIDS/HIV ___Yes ___No
Anemia ___Yes ___No
Arthritis, Rheumatism ___Yes ___No
Artificial Heart Valves ___Yes ___No
Artificial Joints ___Yes ___No
Asthma ___Yes ___No
Bleeding abnormally with,
Extractions or surgery ___Yes ___No
Blood Disease ___Yes ___No
Cancer ___Yes ___No
Chemical dependency ___Yes ___No
Chemotherapy ___Yes ___No
Circulatory Problems ___Yes ___No
Congenital Heart Lesions ___Yes ___No
Cortisone Treatments ___Yes ___No
Cough, persistent/bloody ___Yes ___No
Diabetes ___Yes ___No
Emphysema ___Yes ___No

Epilepsy ___Yes ___No
Fainting/Dizziness ___Yes ___No
Glaucoma ___Yes ___No
Headaches ___Yes ___No
Heart Murmur ___Yes ___No
Heart Problems ____Yes ____No
Hepatitis _____Yes _____No
Herpes ___Yes ___No
High blood pressure ___Yes ___No
Jaundice ___Yes ___No
Kidney Disease ___Yes ___No
Liver Disease ___Yes ___No
Low Blood Pressure ___Yes ___No
Mitral Valve Prolapse___Yes ___No
Nervous Problems ___Yes ___No
Pacemaker ___Yes ___No
Psychiatric Care ___Yes ___No
Radiation Treatment ___Yes ___No

Rheumatic Fever ___Yes ___No
Scarlet Fever ___Yes ___No
Shortness or breath ___Yes ___No
Sinus trouble ___Yes ___No
Skin Rash ___Yes ___No
Special Diet ____Yes ____No
Stroke _____Yes ____No
Swollen Feet/Ankles ___Yes ___No
Swollen Neck Glands ___Yes ___No
Thyroid Problems ___Yes ___No
Tuberculosis ___Yes ___No
Tumor or growth on head
or Neck ___Yes ___No
Ulcer ___Yes ___No
Weight Loss, unexplained ___Yes ___No

Do you wear contact lenses? ___Yes ___No

Women Only:
Are you pregnant? ___Yes ___No Due Date? __________ Nursing? ___Yes ___No Taking birth control? ___Yes ___No

Medications

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Allergies

Please mark (X) any of the following:

Aspirin ____
Barbiturates ____
Codeine ____
Latex ____
Local Anesthetic ____
Penicillin ____
Sulfa ____
Other (Please Specify): ______________________

Pharmacy Name ________________________________ Phone: _________________________

Emergency Contact

Name ____________________________Relationship__________________Phone___________