Drs. Golovan & Golovan
Norman Golovan D.D.S.
Bruce R. Golovan D.M.D.
Family & Cosmetic Dentistry

Thank you for selecting our Dental Health Care team. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The more you communicate to us, enables us to better care for you.

PATIENT INFORMATION:

Name:_____ Date:_____
Address:_____Social Security #:_____
City:_____State:_____Zip:_____
Birthdate:_____Age:___Sex: M F Home #:_____Cell #:_____
E-mail Address:_____
Employer:_____Work #:_____
Whom may we thank for referring you?:_____
Person to contact in case of emergency:_____Phone #:_____

RESPONSIBLE PARTY FOR THIS ACCOUNT:

(IF SAME AS ABOVE LEAVE BLANK)
Name:_____Relationship to Patient:_____
Address:_____Social Security #:_____
City:_____State:_____Zip_____
Home #:_____Cell #:_____Work #:_____
Employer:_____

DENTAL INSURANCE INFORMATION:

Name of Insured:_____Relationship to Patient:_____
Birthdate:_____Social Security #:_____Work #:_____
Name of Employer:_____Employer Address::_____
City:_____State:_____Zip:_____
Insurance Co.:_____Group #:_____Union or Local #:_____
Insurance Co. Address:_____City:_____State:____Zip:_____
Are you covered by a Second Insurance Company? YES NO
If yes, name of Second Insurance Company:_____
Second Insurance Co. Address:_____
City:_____State:_____Zip:_____
Name of Employee for Second Insurance Company:_____
Social Security #:_____Group #:_____Union or Local #_____

(OVER)

DENTAL & MEDICAL HISTORY

Are you happy with your smile? Yes No
If no, what would you like to change? Shade Shape Other:_____
Have you had any serious trouble with past dental treatment? Yes No
If yes, please explain.:_____
Do you fear dental treatment? Yes No
If yes, please explain.:_____
Name of your Physician:_____
Address:_____City:_____State_____Zip:_____
Are you under the continuing care of a Physician? Yes No
Your current Physical Healthy is: Good Fair Poor
Are you taking any non-prescription, prescription medication or drugs? Yes No
If yes, please list.:_____
_____

Are you allergic to or have had any reaction to the following? Circle yes or no.

Local Anesthetics (e.g. xylocain)……Yes No
Penicillin……..Yes No
Other Antibiotics……Yes No
Codeine……Yes No
Aspirin……Yes No

OFICE USE ONLY:UPDATE FORM
DATE:_____DATE:_____
DATE:_____DATE:_____
DATE:_____DATE:_____

Do you have any allergies or sensitivities? Yes No
If Yes, to what?_____

Do you have or have you had any of the following? Please mark if positive:

[ ] Prosthetic Heart Valve
[ ] Mitral Valve Prolapse with Valvular Regurgitation
[ ] Surgically Constructed Systemic-Pulmonary Shunts
[ ] Prosthetic Joint Replacement (e.g. hip, knee,…)
[ ] History of Endocartis
[ ] Heart Murmur
[ ] Rheumatic Fever

Do you currently need to take an antibiotic before you have dental work done? Yes No

If Yes, which one do you usually take? [ ] Amoxicillin [ ] Erythromycin [ ] Clindamycin
[ ] Keflex [ ] Other:_____

Do you have or have you had any of the following? Please mark if positive:

[ ] Heart Attack	[ ] Anemia	[ ] Hepatits
[ ] High Blood Pressure	[ ] Difficulty Breathing	[ ] Cancer
[ ] Low Blood Pressure	[ ] Asthma	[ ] Radiation Treatment
[ ] Cardiac Pacemaker	[ ] Tuberculosis	[ ] Glaucoma
[ ] Respiratory Problems	[ ] Epilepsy	[ ] Arthritis
[ ] Fainting Spells	[ ] Diabetes	[ ] HIV or AIDS

Do you have any problem, condition or disease not listed above? Yes No
If Yes, please explain._____
WOMEN: Are you pregnant? If so, what month of pregnancy?_____

I affirm that the information I have given is correct to the best of my knowledge; I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

Signature:_____Date:_____

Signature of Parent/Guardian:_____Date:_____