



merion village dental
vesha, janikian, voyles

every friendship begins with a smile

welcome!

dr. vesha, dr. janikian, dr. voyles and dr. lauer would like to take this opportunity to thank you for the opportunity to care for you.

new patients, like yourself, who have been invited to join our dental office are a valued part of merion village dental. We know we are doing our best when our patients recommend our services to others. **If could provide the name of the person that invited you to become a patient, we would like to personally thank them. If you were not referred to us by someone, we are interested in knowing how you heard about us.**

who we should thank

What made you decide to schedule an appointment today?

- | | |
|-----------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="radio"/> new to the area and needed a dentist | <input type="radio"/> thought it was time for a check up |
| <input type="radio"/> haven't been to a dentist for a long time | <input type="radio"/> experiencing a dental problem/having pain |
| <input type="radio"/> changing dentists | <input type="radio"/> no reason |
| <input type="radio"/> dissatisfaction with treatment at former office | <input type="radio"/> other _____ |
| <input type="radio"/> inconvenient location | |
| <input type="radio"/> not comfortable in former office | |

Where was the first place you looked for a dentist?

- | | |
|-------------------------------------------|----------------------------------------|
| <input type="radio"/> yellow pages | <input type="radio"/> asked a friend |
| <input type="radio"/> phone book | <input type="radio"/> asked a relative |
| <input type="radio"/> internet _____ | <input type="radio"/> asked a doctor |
| <input type="radio"/> asked your employer | <input type="radio"/> other _____ |

How did you hear about our practice?

- | | |
|----------------------------------------|---------------------------------------|
| <input type="radio"/> yellow pages | <input type="radio"/> television |
| <input type="radio"/> other phone book | <input type="radio"/> friend |
| <input type="radio"/> direct mail | <input type="radio"/> relative |
| <input type="radio"/> newspaper | <input type="radio"/> doctor |
| <input type="radio"/> radio | <input type="radio"/> another dentist |
| | <input type="radio"/> other _____ |

We appreciate you taking the time to offer this feedback!

we will need to gather some information about you in order to begin a new patient record. The information that we are gathering is strictly confidential and will be used for internal office use and insurance purposes only.

personal history

reason for today's visit

date of last dental visit

reason for last dental visit

first name

last name

preferred name

M F
gender (circle one)

street address

city

state

zip

birthdate

age

home phone

work phone

cell phone

email address

social security number

marital status

employer

your position

employer address

city

state

zip

dental insurance plan

plan number

spouse's dental insurance plan

spouse's name

spouse's social security number

spouse's date of birth

name of your physician

physician's phone number

students / minors

college

city

state

zip

full or part time student

major

drivers license number

mother

father

mother's birthdate

father's birthdate

mother's social security number

father's social security number

mother's employer

mother's employer address

mother's work phone number

father's employer

father's employer address

father's work phone number

drivers license number of responsible party

the person bringing a child or minor is ultimately responsible for their account

signature of parent / guardian

date



medical history

please indicate if you have had any of the following medical conditions:

(*antibiotic premedication may be required prior to your appointment)

- | | | |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="radio"/> y <input type="radio"/> n heart failure | <input type="radio"/> y <input type="radio"/> n *artificial hip, knee or other joint | <input type="radio"/> y <input type="radio"/> n HIV positive, ARC AIDS |
| <input type="radio"/> y <input type="radio"/> n heart disease / attack | <input type="radio"/> y <input type="radio"/> n kidney disorders | <input type="radio"/> y <input type="radio"/> n alcoholism |
| <input type="radio"/> y <input type="radio"/> n angina pectoris | <input type="radio"/> y <input type="radio"/> n ulcers | <input type="radio"/> y <input type="radio"/> n drug addiction |
| <input type="radio"/> y <input type="radio"/> n high blood pressure | <input type="radio"/> y <input type="radio"/> n use of tobacco products | <input type="radio"/> y <input type="radio"/> n glaucoma |
| <input type="radio"/> y <input type="radio"/> n *mitral valve prolapse | <input type="radio"/> y <input type="radio"/> n emphysema | <input type="radio"/> y <input type="radio"/> n cortisone medicine |
| <input type="radio"/> y <input type="radio"/> n *heart murmur | <input type="radio"/> y <input type="radio"/> n tuberculosis (TB) | <input type="radio"/> y <input type="radio"/> n hepatitis (type:) |
| <input type="radio"/> y <input type="radio"/> n *rheumatic fever | <input type="radio"/> y <input type="radio"/> n asthma | <input type="radio"/> y <input type="radio"/> n liver disease |
| <input type="radio"/> y <input type="radio"/> n congenital heart lesions | <input type="radio"/> y <input type="radio"/> n sinus problems | <input type="radio"/> y <input type="radio"/> n jaundice |
| <input type="radio"/> y <input type="radio"/> n heart pace maker | <input type="radio"/> y <input type="radio"/> n hay fever | <input type="radio"/> y <input type="radio"/> n blood transfusion |
| <input type="radio"/> y <input type="radio"/> n heart surgery | <input type="radio"/> y <input type="radio"/> n allergies or hives | <input type="radio"/> y <input type="radio"/> n bleeding disorder |
| <input type="radio"/> y <input type="radio"/> n cancer | <input type="radio"/> y <input type="radio"/> n diabetes | <input type="radio"/> y <input type="radio"/> n bruise easily |
| <input type="radio"/> y <input type="radio"/> n anemia | <input type="radio"/> y <input type="radio"/> n radiation treatment | <input type="radio"/> y <input type="radio"/> n cold sores |
| <input type="radio"/> y <input type="radio"/> n stroke | <input type="radio"/> y <input type="radio"/> n chemotherapy | <input type="radio"/> y <input type="radio"/> n herpes |
| <input type="radio"/> y <input type="radio"/> n epilepsy or seizures | <input type="radio"/> y <input type="radio"/> n arthritis | <input type="radio"/> y <input type="radio"/> n *any type of implant |
| <input type="radio"/> y <input type="radio"/> n psychiatric treatment | <input type="radio"/> y <input type="radio"/> n sickle cell disease | <input type="radio"/> y <input type="radio"/> n *any type of transplant |

-
- y n are you currently pregnant? due date: _____
- y n are you nursing?
- y n are you taking birth control pills?

y n are you currently under your physician's care? (if yes, please explain)

y n are you currently taking any medications? (please list medications including over the counter medications, vitamins, or herbal remedies)

y n have you been hospitalized within the last 2 years? (if yes, please explain why)

y n are you allergic to (for example: itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, local anesthetics, latex, metals or any other medication?

y n have you ever had excessive bleeding? (if yes, please explain)

dental history

is there anything that might make you uncomfortable during your visit? (For example cold water or mint toothpaste)

is there anything we can do to make your visit more comfortable?

y n are you interested in replacing your silver or mercury fillings with white restorations?

y n are you interested in learning more about Invisalign?

y n would you be interested in teeth whitening?

y n have you ever had a sleep study?

y n have you ever been told you should wear a CPAP?

y n are you excessively tired during the day?

y n do you have a history of hypertension?

y n have you been told that you gasp for air or stop breathing while sleeping?

y n do you snore?



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