# Pavlick Dental

## 3215 Cleveland Ave. NW  Canton, Ohio 44709

**Dr. David Pavlick  Dr. Kaitlin Johnston  Dr. Kate Pavlick**

## PATIENT INFORMATION

**Name _____DOB _____Female/Male  Soc. Sec. #_____**

**Home address_____City_____State_____Zip_____**

**Home Phone _____Cell Phone _____Work Phone_____**

**E-mail address_____**

**Single  Married  Divorced  Widowed  Separated  Minor  Other**

**Patient Employer_____ Occupation_____**

**Spouse's Name _____DOB_____ Soc. Sec. #_____**

**Spouse's Employer_____Spouse's Employer Phone #_____**

**Person to contact in case of emergency_____phone_____**

**Whom may we thank for referring you to our office?_____**

## DENTAL INSURANCE

**Who is responsible for this account?_____**

**Primary Insurance Company _____Group #_____ID#_____**

**Subscriber's name _____DOB_____ Soc. Sec. #_____**

**Employer_____**

**Is patient covered by additional insurance?  yes  no**

**Secondary Insurance Company _____Group #_____ID #_____**

**Subscriber's name _____DOB_____ Soc. Sec. #_____**

**Relationship to patient_____Employer_____**

**ASSIGNMENT AND RELEASE**

**I certify that I, (and/or my dependents) have insurance coverage with _____and assign directly to Pavlick Dental 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. I consent to the diagnostic procedures and treatment by Pavlick Dental necessary for proper dental care.**

**Signature of Patient, Parent Guardian or Personal Representative**

**_____Date_____**

**Doctor Signature _____ Date _____**

## DENTAL HISTORY

**Reason for today's visit**_____

**Do you have any specific questions or concerns you would like to discuss with the doctor?** _____

_____

**Former Dentist**_____**City/State**_____**Phone number**_____

**Date of last dental visit** _____**Date of last dental x-rays**_____

**Place a mark on yes or no to indicate if you have had any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Missing teeth | yes | no | Head, neck or shoulder aches | yes | no |
| Bad Breath | yes | no | Lip or cheek biting | yes | no |
| Bleeding Gums | yes | no | Loose or chipped teeth | yes | no |
| Blisters on lips or mouth | yes | no | Mouth breathing | yes | no |
| Burning sensation on tongue | yes | no | Mouth pain when brushing | yes | no |
| Chew on one side of mouth | yes | no | Orthodontic treatment | yes | no |
| Cigarette, pipe, or cigar smoking | yes | no | Pain around ear | yes | no |
| How much per day?_____ | | | Periodontal treatment(gum disease) | yes | no |
| How long?_____ | | | Sensitivity to cold | yes | no |
| Clicking or popping jaw | yes | no | Sensitivity to heat | yes | no |
| Dry mouth | yes | no | Sensitivity to sweets | yes | no |
| Fingernail biting | yes | no | Sensitivity when biting | yes | no |
| Food collection between the teeth | yes | no | Sores or growths in your mouth | yes | no |
| Grinding teeth | yes | no | Broken fillings | yes | no |
| Gums swollen or tender | yes | no | Interested in teeth replacement | yes | no |
| Jaw pain or tiredness | yes | no | Happy with the appearance of your teeth | yes | no |

## MEDICAL HISTORY

**Physician name** _____**Phone number**_____

**Date of last visit**_____

**Are you in good health?** _____**If no, explain** _____

**Do you have an existing illness?** _____**If yes, explain**_____

**Have you been hospitalized in the past 2 years?** _____**If yes, explain**_____

**Do you bleed excessively when cut?**_____

**Have you ever taken any of the group of drugs collectively referred to as "fen-Phen?" These include combinations of Lonimin, 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, Boniva, Actonel, Atelvia, Reclast, Aredia, and Zometa. Yes No**

**Have you ever been advised to take an antibiotic prior to dental treatment? Yes No**

**Place a mark on yes or no to indicate if you have had any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Anemia | yes | no | Jaundice | yes | no |
| Arthritis, Rheumatism | yes | no | Jaw Pain | yes | no |
| Artificial Heart Valves | yes | no | Kidney Disease | yes | no |
| Artificial Joints | yes | no | Liver Disease | yes | no |
| Year of placement_____ | | | High Blood Pressure | yes | no |
| Asthma | yes | no | Mitral Valve Prolapse | yes | no |
| Back Problems | yes | no | Nervous Problems | yes | no |
| Bleeding abnormally, with | | | Pacemaker | yes | no |
| extractions or surgery | yes | no | Psychiatric Care | yes | no |
| Blood Disease/Leukemia | yes | no | Radiation Treatment | yes | no |
| Cancer | yes | no | Respiratory Disease | yes | no |
| Chemical Dependency | yes | no | Rheumatic Fever | yes | no |
| Chemotherapy | yes | no | Scarlet Fever | yes | no |
| Circulatory Problems | yes | no | Shortness of breath | yes | no |
| Congenital Heart Lesions | yes | no | Sinus Troubles | yes | no |
| Cortisone Treatments | yes | no | Skin Rash | yes | no |
| Cough, persistent or bloody | yes | no | Stomach problems | yes | no |
| Diabetes | yes | no | Stroke | yes | no |
| Emphysema | yes | no | Swollen Feet or Ankles | yes | no |
| Epilepsy | yes | no | Swollen Neck Glands | yes | no |
| Fainting or dizziness | yes | no | Thyroid Problems | yes | no |
| Glaucoma | yes | no | Tonsilitis | yes | no |
| Headaches | yes | no | Tuberculosis | yes | no |
| Heart Murmur | yes | no | Tumor or growth on head or neck | yes | no |
| Heart problems | yes | no | Ulcer | yes | no |
| Hepatitis Type_____ | yes | no | Venereal Disease | yes | no |
| Herpes | yes | no | Weight loss, unexplained | yes | no |
| Recreational drugs | yes | no | Do you regularly consume more than | | |
| Do you wear contact lens? | Yes | no | 1-2 alcoholic, pop or other sugary drinks | | |
| WOMEN | | | per day? | Yes | no |
| Are you pregnant? | Yes | no | Due Date_____ Are you nursing? | Yes | no |
| Are you taking birth control pills | | yes | no | | |

## MEDICATIONS

**List any medications you are currently taking and the correlating diagnosis and dosage:**

_____
_____
_____
_____
_____
_____

### ALLERGIES

| | | | |
|---|---|---|---|
| Aspirin | Yes no | Local Anesthetic | yes no |
| Iodine | Yes no | Penicillin | yes no |
| Codeine | Yes no | Sulfa | yes no |
| Latex | Yes no | | |

Other_____
_____
_____