



4202 N. 32nd St. Suite B
 Phoenix, AZ 85018
 O: (602) 954-8200
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www.BiltmoreDentalCenter.com

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: _____

I prefer to be called: _____ Male Female

Birth date: _____ SSN: _____

Home address: _____

Hm # _____ Cell # _____

Wk # _____ Pgr # _____

Email _____

How do you prefer to confirm your appointments?

Employer: _____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us?

Previous / Present Dentist: _____

Date of Last Visit : _____ Ph# _____

Dental Insurance
Primary Dental Insurance
Insurance Co. Name: _____
Address: _____
Phone: _____
Group # (Plan, Local, or Policy #) _____
Insured's Name: _____
Relation: _____
Insured's Birth date: _____
Insured's SSN: _____
Secondary Dental Insurance
Insurance Co. Name: _____
Address: _____
Phone: _____
Group # (Plan, Local, or Policy #) _____
Insured's Name: _____
Relation: _____
Insured's Birth date: _____
Insured's SSN: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____

Relation: _____

Wk # _____ Hm # _____

A note for patients with dental insurance – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees.

Medical History

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Are you taking any prescription/over the counter drugs? Yes No

Please list: _____

Do you need antibiotic pre-medication prior to a dental visit? Yes No

Do you use or smoke tobacco in any form? Yes No

Have you ever taken Redux. / Fen Phen / Pondimin Yes No

For women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No week# _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

- | | |
|---|--|
| <p>Y <input type="checkbox"/> N <input type="checkbox"/> Abnormal Bleeding</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Alcohol/Drug Abuse</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Anemia</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Arthritis</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Artificial Bones/Joints/Valves</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Asthma</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Blood Transfusions</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Cancer/Chemotherapy</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Colitis</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Congenital Heart Defect</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Difficulty Breathing</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Emphysema</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Fainting Spells</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Frequent Headaches</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Glaucoma</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Hay Fever</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Heart Attack</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Heart Murmur</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Heart Surgery</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Hemophilia</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis</p> | <p>Y <input type="checkbox"/> N <input type="checkbox"/> Herpes/Fever Blisters</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> High Blood Pressure</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> HIV+/AIDS</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Hospitalized Any Reason</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Kidney Problems</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Latex Allergy</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Liver Disease</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Low Blood Pressure</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Mitral Valve Prolapse</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Nervous/Anxious</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Pacemaker</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Psychiatric Problems</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Radiation Treatment</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Rheumatic/Scarlet Fever</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Seizures</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Shingles</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Sickle Cell Disease</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Sinus Problems</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Stroke</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Thyroid Problems</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Tuberculosis</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Ulcers</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Venereal Disease</p> |
|---|--|

Please list any other serious medical condition(s) that you have ever had:

Are you allergic to any of the following items?

- | | |
|---|---|
| <p>Y <input type="checkbox"/> N <input type="checkbox"/> Aspirin</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Codeine</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Dental Anesthetics</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Erythromycin</p> | <p>Y <input type="checkbox"/> N <input type="checkbox"/> Latex</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Penicillin</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Tetracycline</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Other</p> |
|---|---|

Please list any other drugs you are allergic to:

Dental History

Many patients consult us for a 2nd opinion. Are you currently seeing another dentist for your dental needs? Yes No

Please explain: _____

How would you describe the condition of your teeth and gums?
 Good Fair Poor

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? Yes No

Do your gums bleed when you floss? Yes No

Have you ever experienced pain in your jaw joint? Yes No

Have you ever been treated for TMJ symptoms? Yes No

Please explain: _____

Do you wake up with headaches? Yes No

Times / week: _____

Do you get headaches during the day? Yes No

Times / week: _____

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

I authorize the doctor and his staff to perform any necessary dental services that I may need during the diagnosis and treatment of my dental condition. I understand that Dr. Koppikar is adjunct faculty at the Arizona School of Dentistry and I give him and his office permission to use any photos taken for lecturing, publishing, educational, or promotional purposes.

Patient portion is due in full at the time of treatment.

Patient Name: _____

Signature _____ Date _____

Doctor Signature _____

Updated Medical History/Consent

Signature _____ Date _____

Sameet Koppikar, DDS

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Getting To Know You... Name: _____

Welcome to Biltmore Dental Center- we welcome you to our dental family!

Let us get acquainted...

Hobbies & Interests:

Family? Children? Pets? ... (ages)

Business/Occupation:

Today's dentistry allows us to enhance your smile quickly and easily. How would you like your smile to look? (circle what applies)

- Straighter
- Whiter
- Shorter
- Wider
- Longer
- More Even
- Close Spaces
- Replace Missing or Cracked Teeth
- Replace Partial / Dentures
- Fresher Breath

Other Reasons for today's visit:

When would you like to begin?
