BURBA DENTAL PARTNERS

Advanced Cosmetic Dentistry

Dr. Randy Burba, D.M.D & Dr. Stanley Burba, D.D.S & Dr John Costello, D.M.D

PATIENT INFORMATION

Name: _____ Date of Birth ____/____/_____ Social Security # ____-____-____

Address:_____ City:_____ State:_____ Zip:_____

Telephone numbers: (H) ( ) - (Cell) ( ) -

Employer: _____ Email:_____

Physician:_____ Address:_____ Tel. # ( ) -

Pharmacy: _____ City/Town:_____

Emergency Contact Person/Relationship:_____ Tel.# ( ) -

INSURANCE INFORMATION Do you carry dental insurance? Yes No

Insurance Company:_____ Insured Name: _____

Insured S.S. # _____-_____-_____ Insured Date of Birth: _____/_____/_____ Insured Employer:_____

Group # _____ Insurance ID # _____

MEDICAL INFORMATION

Please List **ALL** Medications Currently Taking:

Medication:	Medical Condition:	Dosage:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do **you have** or **have had** any of the following problems: Please check all that apply

__Allergies	__Blood Transfusions	__Epilepsy	__Hepatitis A/B/C
__Anemia	__Cancer/Chemo/Radiation	__Fainting Spells	__HIV/AIDS
__Angina Pectoris	__Congenital Heart	__Headaches/Migraines	__Kidney/Liver Problems
__Arthritis	__Cosmetic Surgery	__Glaucoma	__High/Low Blood Pressure
__Artificial Bones	__Diabetes	__Heart Attack/Stroke	__Mitral Valve/Pacemaker
__Artificial Heart	__Drug Abuse	__Heart Surgery	__Seizures
__Asthma	__Emphysema	__Hemophilia	__Thyroid Problems

Please list any serious <u>illnesses</u> or hospital stays:

_____

<u>ARE YOU TAKING:</u> VITAMIN E, BABY ASPIRIN, REGULAR ASPIRIN OR ANY BLOOD THINNER YES or NO (circle)

Are you **allergic** to any of the following: Local Anesthetics Penicillin Sulfa Aspirin Codeine
Other allergies:_____

Are you experiencing any Dental problems?_____

Have you had any serious problems associated with any previous dental treatment? _____

_____

Do you (circle all that apply) Smoke? Grind your teeth? Snore? Have gums that bleed easily?

Patient/Guardian Signature: _____ Date _____/_____/_____