Paul M. Pavloff, DDS
6518 Winford Avenue
Fairfield Twp., OH 45011
Phone: (513) 867-0619

PATIENT INFORMATION

Today's date _____

Name: _____ I prefer to be called: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

Address: _____ Zip Code: _____

Please Circle One: Sex: M F Minor Single Married Widowed

Home Phone: _____ Cell Phone: _____

Drivers License #: _____ Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Employer's Phone: _____

Who may we thank for referring you: _____

Other Family members seen by us: _____

EMERGENCY CONTACT

In case of emergency, who should we contact: _____

Emergency Phone: _____ Relationship to you: _____

SPOUSE INFORMATION

Name: _____ Birthdate: _____

Soc. Sec. #: _____

Employer: _____ Work Phone: _____

PRIMARY DENTAL INSURANCE

Insurance Name: _____

Insurance Address: _____ Phone: _____

Group #: _____ Subscriber ID #: _____

Insured's Name: _____

Birthdate: _____ Soc. Sec. #: _____ Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Name: _____

Insurance Address: _____ Phone: _____

Group #: _____ Subscriber ID #: _____

Insured's Name: _____

Birthdate: _____ Soc. Sec. #: _____ Employer: _____

DENTAL HISTORY

Former Dentist: _____ Date of last x-rays: _____

City, State: _____ How often do you floss? _____

Date of last dental visit: _____ How often do you brush? _____

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Have you ever had a reaction to dental anesthetic or novocaine? Yes No

Are you currently in pain or discomfort? Yes No

MEDICAL HISTORY

Physician's Name _____ Date of last visit: _____

1. Are you currently under medical treatment: Yes No
   Please Explain: _____
   _____
2. Have you ever had any serious illnesses or operations: _____ Yes No
   _____
   _____
3. Are you currently taking any medication Yes No
   Please List: _____
   _____
   _____
4. (Women) Are you pregnant? Yes No
   Are you on birth control? Yes No
5. Do you Smoke? Yes No

Allergies

Are you allergic to the following:

Penicillin	Yes	No
Sulfa Drugs	Yes	No
Codeine	Yes	No
Aspirin	Yes	No
Erythromycin	Yes	No
Tetracyclines	Yes	No
Latex	Yes	No
Other	Yes	No

Please explain: _____
_____

Diseases and Medical Conditions

Have you ever had any of the following diseases or conditions? Please Circle Yes or No

AIDS / HIV	Yes	No	High Blood Pressure	Yes	No
Anemia	Yes	No	Jaundice	Yes	No
Arthritis	Yes	No	Jaw Pain	Yes	No
Artificial Heart Valve	Yes	No	Kidney Disease	Yes	No
Artificial Joint(s)	Yes	No	Liver Disease	Yes	No
Asthma	Yes	No	Low Blood Pressure	Yes	No
Bleeding Disorders	Yes	No	Mitral Valve Prolapse	Yes	No
Caner	Yes	No	Pacemaker	Yes	No
Congenital Heart Condition	Yes	No	Psychiatric Care	Yes	No
Cortisone Treatments	Yes	No	Respiratory Disease	Yes	No
Diabetes	Yes	No	Rheumatic Fever	Yes	No
Drug / Alcohol Abuse	Yes	No	Scarlet Fever	Yes	No
Emphysema	Yes	No	Sinus Trouble	Yes	No
Epilepsy	Yes	No	Skin Rash	Yes	No
Glaucoma	Yes	No	Stroke	Yes	No
Headaches	Yes	No	Thyroid Problems	Yes	No
Heart Murmur	Yes	No	Tonsillitis	Yes	No
Hepatitis Type -	Yes	No	Tuberculosis	Yes	No
Fever Blisters	Yes	No	Ulcer	Yes	No

ACCOUNT INFORMATION

Person responsible for account: _____

Relationship to patient: _____ Birthdate: _____ Soc. Sec. #: _____

Address: _____

Home Phone: _____ Cell Phone: _____

I authorize payment of dental insurance benefits to Dr. Paul Pavloff for services provided to me or any member of my family. I understand that I am financially responsible for all charges, whether or not paid by insuramnce, and for all services rendered on my behalf or my dependents.

Signature of Responsible Party: _____ Date: _____