Specialty Prosthodontic Care • Comprehensive Restorative & Implant Dentistry

Patient Information Please print clearly

Legal Last Name _____ **First Name** _____ **Middle Initial** _____

Preferred Name _____ **Date of Birth** _____ **Age** _____

Mailing Address _____

City _____ **State** _____ **ZIP Code** _____

Email Address _____

Mobile Phone _____ **Home / Alternate Phone** _____

Employer _____ **Occupation** _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Widowed

Responsible Party / Parent or Guardian Complete if different from patient

Name _____ **Relationship** _____ **Phone** _____

Employer _____ **Date of Birth** _____

Referral & Care Team

Who may we thank for referring you? _____

How did you hear about us? ☐ Referring Dentist ☐ Family/Friend ☐ Google/Web ☐ Social Media ☐ Insurance ☐ Other

General Dentist / Practice _____ **Phone** _____

Physician / Primary Care Provider _____ **Phone** _____

Your Reason for Visiting Us Help us understand what matters most to you

What brings you to our prosthodontic practice today?

☐ Missing teeth ☐ Failing / broken teeth ☐ Dental implants ☐ Dentures / partials ☐ All-on-X / full-arch treatment

☐ Crowns / bridges ☐ Veneers / cosmetic concerns ☐ Bite / chewing problems ☐ Second opinion ☐ Full-mouth reconstruction ☐ Other

Please describe your primary concern in your own words:

_____

_____

What would a successful result look or feel like to you?

_____

_____

Priorities for Your Care

Which are most important to you? ☐ Natural appearance ☐ Comfort ☐ Chewing/function ☐ Durability ☐ Preserving teeth ☐ Treatment time ☐ Other

A focused history helps us understand the function, comfort, and longevity of your smile.

Previous Dental & Prosthodontic Treatment

Restorative History
☐ Crowns
☐ Bridges
☐ Veneers
☐ Large fillings
☐ Root canal treatment
☐ Full-mouth rehabilitation

Implant History
☐ Dental implants
☐ Implant crowns / bridges
☐ All-on-X / fixed hybrid
☐ Implant overdenture
☐ Bone grafting
☐ Sinus lift

Removable Prosthetics
☐ Complete denture
☐ Partial denture
☐ Overdenture
☐ Nightguard / splint
☐ Current removable appliance

Orthodontic / Other
☐ Braces
☐ Clear aligners
☐ Periodontal treatment
☐ Oral surgery
☐ TMJ treatment
☐ Sedation dentistry

Approx. date of last cleaning _____

Last complete dental X-rays _____ **Previous Dentist** _____

Have you had dental treatment that did not meet your expectations? If yes, please describe:

_____

_____

Current Function & Comfort Check any that apply

Teeth / Restorations
☐ Broken or chipped teeth
☐ Loose teeth
☐ Loose crown / bridge
☐ Food trapping
☐ Sensitivity to hot/cold/sweets
☐ Pain with biting / chewing

Bite / Jaw
☐ Grinding or clenching
☐ Jaw joint pain
☐ Clicking / popping
☐ Headaches / facial pain
☐ Bite feels uneven
☐ Difficulty opening / closing

Gum / Oral Health
☐ Bleeding or swollen gums
☐ History of gum disease
☐ Bad breath
☐ Dry mouth
☐ Frequent mouth sores
☐ Oral cancer history

Function
☐ Difficulty chewing
☐ Avoid certain foods
☐ Chew mostly on one side
☐ Speech concerns
☐ Gag reflex concerns
☐ Mouth breathing

Smile & Esthetic Concerns

What would you like to improve? ☐ Color ☐ Shape ☐ Length ☐ Alignment ☐ Spaces ☐ Missing teeth ☐ Gum display ☐ Overall smile

Is there anything about your current smile or previous dental work that you especially like or dislike?

_____

_____

Dental Experience & Comfort

How do you generally feel about dental treatment? ☐ Comfortable ☐ Somewhat anxious ☐ Very anxious

Previous comfort options used: ☐ Nitrous oxide ☐ Oral sedation ☐ IV sedation ☐ None

Anything we can do to make your visits more comfortable?

_____

Habits & Lifestyle

☐ Tobacco / nicotine ☐ Alcohol ☐ Recreational drugs ☐ Nail biting ☐ Chewing ice / objects ☐ None

Tobacco / nicotine amount & duration _____

Alcohol frequency _____

Please answer completely. Your health history can directly affect dental and implant treatment.

Medical Conditions

Check any condition you have or have had

Heart / Circulation

☐ Angina / chest pain
☐ Artificial heart valve
☐ Heart condition / surgery
☐ High / low blood pressure
☐ Pacemaker
☐ Rheumatic fever
☐ Stroke

Blood / Immune

☐ Anemia
☐ Blood disorder
☐ Bruise easily
☐ Excessive bleeding
☐ HIV / AIDS
☐ HPV
☐ Tuberculosis

Endocrine / Organ

☐ Diabetes
☐ Thyroid disease
☐ Kidney disease
☐ Liver disease
☐ Hepatitis A / B / C
☐ Jaundice
☐ GI disease / ulcers

Musculoskeletal

☐ Arthritis
☐ Rheumatoid arthritis
☐ Artificial joint
☐ Osteopenia / osteoporosis
☐ Bone disease
☐ Jaw joint pain

Neurologic / Behavioral

☐ Anxiety
☐ Depression
☐ Dizziness / fainting
☐ Seizures
☐ Psychiatric illness
☐ Drug / alcohol addiction

Respiratory / Sleep

☐ Asthma
☐ Emphysema
☐ Respiratory problems
☐ Sinus problems
☐ Sleep apnea
☐ Snoring

Cancer / Treatment

☐ Cancer
☐ Chemotherapy
☐ Radiation therapy
☐ Head / neck radiation

Other

☐ Currently pregnant
☐ Nursing
☐ Other significant condition
☐ Hospitalization in past 5 years

Medications & Bone Health

Are you currently taking prescription or over-the-counter medications, vitamins, herbal or dietary supplements? ☐ Yes ☐ No

Please list medication / supplement name and reason:

_____

_____

Have you ever taken medication for osteoporosis, osteopenia, cancer-related bone disease, or other bone conditions? ☐ Yes ☐ No

If yes, please list the medication(s), approximate dates, and reason:

_____

Allergies & Reactions

☐ Penicillin / Amoxicillin ☐ Clindamycin ☐ Opioids ☐ NSAIDs ☐ Latex ☐ Local anesthetics ☐ Other

Please describe any allergy or medication reaction:

_____

Physician & Surgical History

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

Physician / Specialist _____ **Phone** _____

Please list significant surgeries, serious illnesses, or hospitalizations:

_____

_____

Medical & Dental Consent

I certify that the information provided in this health history is accurate and complete to the best of my knowledge. I understand that changes in my health, medications, or allergies should be reported to the practice. I authorize Dr. Cokovska and the clinical team to obtain diagnostic records, including radiographs, photographs, scans, study models, and other diagnostic aids considered appropriate for evaluation and treatment planning. I understand that treatment recommendations will be discussed with me and that specific procedures may require separate informed consent.

Patient / Legal Guardian Signature _____ **Date** _____

Please review carefully and sign where indicated.

Financial & Insurance Policy

Makris Dental Prosthodontics is an out-of-network provider and does not participate in or have a contracted fee agreement with dental insurance companies. The professional and financial relationship is with you, the patient. Your dental insurance policy is a contract between you, your employer (if applicable), and your insurance company.

Payment is due at the time services are provided unless other financial arrangements have been approved in advance. We accept cash, certified checks, credit cards, and third-party patient financing. Returned checks and overdue balances may be subject to applicable fees in accordance with office policy and applicable law.

As a courtesy, our office may submit dental insurance claims and supporting documentation on your behalf. Claim submission does not guarantee coverage, payment, or reimbursement. It is your responsibility to understand your benefits and to follow up directly with your insurance company regarding claim status, delays, denials, reimbursement, deductibles, coinsurance, annual maximums, waiting periods, exclusions, frequency limitations, and other plan restrictions.

You are financially responsible for the full cost of treatment and services provided, regardless of whether your insurance company pays, delays payment, denies a claim, pays less than anticipated, or determines that a service is not covered.

☐ **I would like information about financing options.**

Patient / Responsible Party Signature _____ **Date** _____

Emergency Contact

Emergency Contact Name _____ **Relationship** _____ **Phone Number** _____

If I do not designate an emergency contact and an emergency occurs in which I am unable to communicate or make decisions, I authorize the office to use reasonable professional judgment to take appropriate steps necessary to protect my health and safety, including contacting emergency medical services and, when appropriate and permitted by law, attempting to identify and contact a family member, personal representative, caregiver, or other individual who may reasonably be able to assist. I understand that, if emergency medical services are deemed necessary during or in connection with my care, I am financially responsible for any charges associated with emergency medical care, ambulance transportation, hospital services, or other services provided by third-party medical providers. I understand that Makris Dental Prosthodontics and Dr. Cokovska are not responsible for charges incurred for such third-party emergency medical services.

Authorization to Discuss My Care Optional

I authorize this office to discuss information regarding my dental care, treatment, appointments, health information, and financial matters with the individual(s) listed below. I also authorize those individuals to be present during appointments and treatment or financial discussions when permitted by me and when appropriate.

Name _____ **Relationship** _____

Name _____ **Relationship** _____

I understand that I may change or revoke this authorization by notifying the office, subject to applicable law.

Patient / Responsible Party Signature _____ **Date** _____

Notice of Privacy Practices

I acknowledge that I have received a copy of this office's Notice of Privacy Practices, which explains how my health information may be used, disclosed, and protected.

Patient Name (Printed) _____ **Signature** _____ **Date** _____

For Office Use Only

If written acknowledgment could not be obtained: ☐ Refused to sign ☐ Communication barrier ☐ Emergency ☐ Other: _____

Acknowledgment

By signing below, I acknowledge that I have reviewed the information in this new patient packet, had an opportunity to ask questions, and understand my responsibilities regarding the accuracy of information provided, financial obligations, insurance follow-up, and communication with the practice.

Patient / Responsible Party Signature _____ **Date** _____