Plastic Surgery for Your Smile
Carrie Berkovich, DDS, MS

450 Sutter Street, Suite 1739
San Francisco, CA 94108

Cosmetic Periodontics and Dental Implants

WELCOME TO OUR OFFICE

Patient Information

Name_____ Date of Birth_____ SS#_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone _____ Other Phone_____ E-Mail_____
Spouse/Partner_____ Employer_____
Insured's Name_____Relationship_____Subscriber ID#_____
Insurance Company_____ Plan Name_____ Group #_____
Secondary Insurance_____ Plan Name_____ Group#_____
Emergency Contact_____ Phone Number_____
Who may we thank for referring you to our office?_____

Dental History

What is the reason for your visit?_____
When was your last full mouth x-ray series taken? _____ When was your last cleaning?_____
Do you brush and floss regularly?_____ Do you use a powered toothbrush (Sonicare)?_____
Do your gums bleed? _____Does food catches between your teeth? _____
Are your teeth sensitive to cold/hot?_____ What other dental cleaning aids do you use?_____
Do you have discomfort or clicking in your jaw? _____ Do you like your smile? _____

Medical History

Are you currently under a physicians care?_____ Reason_____
Physician _____ Address _____ Phone_____
Have you been hospitalized or had a major operation? Explain_____
Are you in good health?____ Do you bruise easily?_____ Do you smoke?_____ If yes, how often_____
Are you taking any medications?____ If yes, please list_____
Are you allergic to any medications?_____ If yes, please list_____
Latex Allergy?_____ Are you pregnant?_____ Nursing?_____ Trying to get pregnant?_____

Do you have, or have you had any of the following?

Heart Disease	☐	High Blood Pressure	☐	AIDS/HIV +	☐
Diabetes	☐	Low Blood Pressure	☐	Radiation Treatment	☐
Stroke	☐	Blood Disease	☐	Tumor History	☐
Heart Murmur	☐	Recent Blood Transfusion	☐	Chemotherapy	☐
Epilepsy	☐	Asthma	☐	Liver Disease	☐
Kidney Disease	☐	Cortisone Medicine	☐	Drug/Alcohol Addiction	☐
Rheumatic Fever	☐	Tuberculosis	☐	Venereal Disease	☐
Arthritis	☐	Stomach/Intestinal Disease	☐	Psychiatric Care	☐
Pace Maker	☐	Ulcer	☐	Thyroid Disease	☐

Remarks_____

I have completed this form and confirm that it adequately describes my condition. I shall inform my doctor and staff of any changes to my health status.

X_____ **Date**_____
Patient Signature