Dr. Michele Harutunian D.D.S., P.C.
340 Dogwood Avenue - Suite 110
Franklin Square, New York 11010

Dental Oral History

Date of last dental exam: _____ Date of last x -rays: _____
Are you in good health? _____

Has there been any change in general health in the last 5 years?	Yes	No
Do your gums bleed when you brush?	Yes	No
Are you happy with your SMILE?	Yes	No
Would you like to change your SMILE?	Yes	No
Do you smoke CIGARETTES, CIGARS, and or PIPE?	Yes	No
Are your teeth discolored?	Yes	No
Would you like to WHITEN your teeth?	Yes	No
Are your teeth sensitive to HOT, COLD, CHEWING?	Yes	No
Do you grind or clench your teeth at night or during the day?	Yes	No

HAVE YOU EVER BEEN PRE-MEDICATED WITH ANTIBIOTICS BEFORE ANY DENTAL PROCEDURES?
_____

MEDICAL HISTORY

DO YOU CURRENTLY HAVE OR HAD IN THE PAST ANY OF THE FOLLOWING CONDITIONS?

			Explanation
Hemophilia	Yes	No	_____
Mitral Valve Prolapse/ Heart Murmur	Yes	No	_____
Heart Attack/Angina/ Heart Disease	Yes	No	_____
Pacemaker/ Irregular Heartbeat	Yes	No	_____
High Blood Pressure	Yes	No	_____
Congenital Heart Disease	Yes	No	_____
Heart Surgery (bypass, stent, transplant)	Yes	No	_____
Asthma/ Emphysema/ difficult breathing	Yes	No	_____
Seizures/ Epilepsy/ Convulsions	Yes	No	_____
CANCER/ CHEMOTHERAPY/ RADIATION THERAPY	Yes	No	_____
Artificial Joints	Yes	No	_____
Osteoporosis	Yes	No	_____
Are you taking BISPHOSPHONATES	Yes	No	_____
Stroke	Yes	No	_____
Diabetes Type I or II	Yes	No	_____
CoVID-19	Yes	No	_____

Thyroid Condition	Yes	No _____
Alcohol Use	Yes	No _____
Tobacco Use	Yes	No _____
Prostate Problem	Yes	No _____
Kidney Disease/Transplant	Yes	No _____
Hepatitis/ Liver disease/ cirrhosis/ Liver Transplant	Yes	No _____
Crohn's Disease	Yes	No _____
Stomach Ulcers/ Heartburn/ Acid reflux/ Hernia	Yes	No _____
Tuberculosis	Yes	No _____
Rheumatic Fever/ Rheumatic Heart Disease	Yes	No _____
Autoimmune Disease/ Lupus/ Scleroderma/ MS	Yes	No _____
Blood Disorder	Yes	No _____
Anemia/ Sickle Cell Anemia/ Hemophilia	Yes	No _____
Bleeding Disorder/ Coagulation Disorder	Yes	No _____
Leukemia/ Lymphoma/ Multiple Myeloma	Yes	No _____
Psychiatric Treatment	Yes	No _____
Depression	Yes	No _____
HIV/ AIDS	Yes	No _____
Herpes	Yes	No _____
Venereal Disease/Syphilis/Gonorrhea	Yes	No _____

Other Conditions: _____

WOMEN:	Are you **PREGNANT**?	Yes No	I don't know
	Are you taking birth control pills?	Yes No	
	Are you nursing:	Yes No	

ALLERGIES TO MEDICATION

Penicillin	Yes	No	Codeine	Yes	No
Sulfur	Yes	No	Aspirin	Yes	No
Erythromycin	Yes	No	Metal	Yes	No
Tetracycline	Yes	No	Food	Yes	No
Novocaine (Dental Anesthetic)	Yes	No	Sedatives	Yes	No
Latex	Yes	No			

Other: _____

WHAT MEDICATIONS ARE YOU TAKING?

_____

_____

Have you had orthopedic total joint (hip, elbow, knee,) replacement?_____
Date done: _____

Are you taking ASPRIN on a regular basis? _____
Did you take or are you currently taking BISPHOSPHONATES? _____
Are you PRE-MEDICATING for dental procedures?_____

Your Physician's Name: _____
Phone: _____

Address: _____
Date of last physical examination? _____

I hereby authorize Michele Harutunian D.D.S., P.C. to conduct all diagnostic tests necessary and proper so Harutunian D.D.S. may determine and formulate a dental treatment plan. Diagnostic procedures may include but not limited to intra and extra-oral photography, x-rays and diagnostic models.
I agree to the treatments, procedures, administration of medications and anesthesia that may be necessary. I understand that dentistry is not an exact science and therefore dental practitioners such as Harutunian D.D.S. cannot fully guarantee any result.
I further agree that all fees for services are due and payable either before or after the treatment at the sole discretion of Harutunian D.D.S.
I shall immediately notify Harutunian D.D.S. of any changes in my medical history (e.g. new conditions, new medications, new allergies, etc.) as well as any changes in my contact information.
I understand that Harutunian D.D.S. reserves the right to change the terms of its Privacy Practices and to make changes regarding all protected health information stored by Harutunian D.D.S. I understand that I can obtain a copy of Harutunian D.D.S. current Privacy Practices upon request. I understand that in the event that I am unable to attend a dental appointment for whatever reason, Harutunian D.D.S. shall have the right, in its sole discretion, to charge me for such no-show appointment.

Date: _____

Patient or Authorized Person Name: _____

Signature: _____