Alexander M Barsky, DDS

(516)825-3247

Patient Name: ______________________ ______________________ ___ ______________________
Last First MI Preferred Name

Patient Dental History

Reason for this visit

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When was your last dental visit ______________

How often did you visit the dentist before then ______________

Do your gums bleed while brushing ◯ Yes ◯ No

Have you ever received oral hygiene instructions regarding the care of your teeth and gums ◯ Yes ◯ No

Are your teeth sensitive to hot or cold liquids/foods ◯ Yes ◯ No

Are your teeth sensitive to sweet or sour liquids/foods ◯ Yes ◯ No

Do any of your teeth feel painful ◯ Yes ◯ No

Have you had any head, neck, or jaw injuries ◯ Yes ◯ No

Do you have frequent headaches ◯ Yes ◯ No

Do you grind or clench your teeth ◯ Yes ◯ No

Have you noticed any loosening of your teeth ◯ Yes ◯ No

Does food tend to become caught between your teeth ◯ Yes ◯ No

Have you ever had gum (periodontal) treatment/surgery ◯ Yes ◯ No

Have you ever worn a bite plate or other appliances ◯ Yes ◯ No

Have you had any difficult extractions ◯ Yes ◯ No

Have you ever had prolonged bleeding after extractions ◯ Yes ◯ No

Do you have any missing teeth ◯ Yes ◯ No

Do you like your teeth ◯ Yes ◯ No

Do you like your smile ◯ Yes ◯ No

I am pleased when I look at my teeth in the mirror ◯ Yes ◯ No

If you could change ANYTHING about your smile, what would you change?

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Have you ever been told that you snore ○ Yes ○ No

Do you generally feel tired when you wake up ○ Yes ○ No

Do you feel sluggish or tired during the day ○ Yes ○ No

Have you ever been tested for or diagnosed with SLEEP APNEA ○ Yes ○ No

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Are some of your teeth crooked or misaligned ○ Yes ○ No

Do you find it difficult to keep the crooked or misaligned teeth clean or stain-free ○ Yes ○ No

Do you find that food gets caught more frequently in the areas where teeth are crooked or misaligned ○ Yes ○ No

What would you like to know about correcting the crooked or misaligned teeth with INVISALIGN TREATMENT

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Do you have a "gummy smile" ○ Yes ○ No

Have you ever had Botox or other facial injectables to enhance your appearance and improve your look or smile ○ Yes ○ No

Have you ever had Dermal Fillers to help minimize the appearance of facial lines and wrinkles ○ Yes ○ No

What would you like to know about BOTOX or DERMAL FILLERS?

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AUTHORIZATION AND RELEASE

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

Signature ____ **Date** __________

Response Date: ____/____/_______