Dr. Norman Bressack D.D.S. P.C.

PATIENT INFORMATION

Patient's Name _____ Age_____ Birthday_____
Name you would like to be called_____ Home No._____
Cell No._____ Can you receive text msgs? _____
E-Mail Address_____
Address_____ City_____ State_____ Zip Code_____
Social Security No._____
Who shall we thank for referring you to our office?_____

SPOUSE /ADDITIONAL CONTACT INFORMATION

Name_____
Address_____ City_____ State_____ Zip Code_____
How long at this address?_____
Social Security No._____ Birthday_____ Relationship to Patient_____
Employer_____ Occupation_____

INSURANCE INFORMATION

Insured Name_____ Insured S.S. #_____ Insurance Co._____
Insurance Company Address_____ Group No._____
Phone_____ Insured's Employer_____
Do you have duel coverage? ____Y ____N If yes:
Insured Name_____ Insured I.D. #_____ Insured Employer_____
Ins. Co. Address_____ Group #_____ Phone _____

MEDICAL / DENTAL HISTORY (circle)

Physician's Name_____ Phone_____

Dentist's Name_____ Phone_____

Yes No Are you currently under any medical treatment? If so…What kind?_____
Yes No Do you have pain, clicking, and or popping noises in the jaw?
Yes No Are you aware of either clenching or grinding of your teeth?
Yes No Do you have frequent headaches? How often? _____
Yes No Do you have ear problems? (Aches, ringing, dizziness, fullness)
Yes No Do you have difficulty breathing through your nose?
Yes No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?
Yes No Do you have speech problems, or are you in speech therapy?
Yes No Have you had your tonsils/adnoids removed?

Have there been any history of (CHECK ANY THAT APPLY)
Joint swelling ☐ Arthritis/rheumatism ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐
Asthma ☐ TB ☐ HIV ☐ kidney/liver ☐ Hepatitis Type ☐