ANDREW I. PUPKIN, D.D.S., P.A.

General, Reconstructive & Aesthetic Dentistry

Andrew I. Pupkin, D.D.S.
Steven A. Nachman, D.D.S.

21 Crossroads Drive
Suite 350
Owings Mills, MD 21117
(410) 581-1411

Dear Patient:

We are pleased you have selected our practice to help you maintain good oral health and to help you solve any dental problems. Our office has been designed for your comfort and safety and we are prepared to make your visits pleasant and effective experiences.

During your initial visit, except for emergency situations requiring immediate treatment, a thorough examination is performed. In virtually all cases a panoramic radiograph or full-mouth series of x-rays will be taken. In some situations, diagnostic casts, a dietary analysis, or other fact-finding material will be collected. The initial examination is not limited to detecting dental decay, but will include an evaluation of the following:

(1) periodontal tissues (the gums and supporting bone);
(2) occlusion of the teeth (the manner in which your teeth come together);
(3) the effect the occlusion may have on the teeth; and
(4) the temporomandibular joint and muscles of the face.

An oral cancer screening will also be conducted during the initial visit. If necessary we may recommend consultation with other dental specialists or your physician.

It is our desire to remedy currently existing dental problems and reveal subtle changes which may cause serious problems in the future. This is what prevention is all about and it is our goal to teach you how to control disease before it can cause irreparable loss or the need for further treatment.

At the conclusion of the initial visit, a program will be discussed with you that will allow you to achieve good, preventive dental care. We are prepared to make your mouth more comfortable, functional and attractive, but only you can make it healthy. That is why it is our ultimate goal to teach and motivate you to achieve dental health through your own daily efforts and eliminate the need for constant dental treatment.

Sincerely,

Andrew I. Pupkin, D.D.S., PA. Steven A. Nachman D.D.S.

PATIENT REGISTRATION

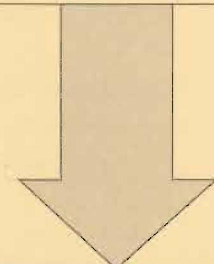
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE			1
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE	2
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	



GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

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Thank you for choosing our office for your dental care. We are committed to the success of your treatment. Payment of your bill is considered a part of your commitment to treatment.

FINANCIAL AGREEMENT:
The following is a statement of our financial agreement which we ask you to read and sign prior to any treatment. YOUR CO-PAY & DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF TREATMENT. To accommodate you, we accept cash, checks, Visa, MasterCard, Discover, and American Express. For extensive treatment plans we offer extended payment plans with prior credit approval. Interest will be charged at a monthly rate of 1.5% for accounts that are past due. If your account is sent to our collection agency, you will be responsible for any and all costs involved. This will include court costs or attorney's fees.

REGARDING INSURANCE: We will accept assignment of your insurance benefits. However, we do require your co-payment and deductible to be paid in full at the time of the visit. The balance is your responsibility whether or not your insurance carrier pays for your treatment. We will gladly process your claims provided you give us accurate insurance information. It is YOUR responsibility to inform us of changes in your insurance coverage. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered services under the policy your employer has selected. However, if a service is not covered, it is your financial responsibility.

MISSED APPOINTMENTS: Please help us serve you and our other patients better by keeping scheduled appointments. Appointments that are missed or changed at the last minute are then unavailable to patients who need them.

COMMITMENT: Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions.
I have read and understand and agree to this financial agreement.

X______________________________________ ________________________

X Signature of Patient or Responsible Party Date

Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

1. Physician's Name ______________________ Phone ( ) ______________
   Have you had any medical care within the past two years? .... Yes No
   Describe ______________________
2. Have you taken any medication or drugs during the past two years? .... Yes No
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? .... Yes No
   If yes, please list name and dosage ______________________
4. Have you ever taken prescription medications for weight loss (diet pills)? .... Yes No
   If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues? .... Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? .... Yes No
6. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? .... Yes No
   If yes, please specify ______________________
7. Have you been a patient in the hospital during the past five years? .... Yes No
8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle) ...	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice ..	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No			

9. Have you lost or gained more than 10 pounds in the past year? .... Yes No
10. Do you have or have you had any disease, condition, or problem not listed? .... Yes No
    If yes, please list: ______________________
11. **Women:** Are you pregnant or think you could be pregnant? Yes ______ Months No **Nursing?** Yes No
12. Do you use birth control prescriptions? .... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature ______________________ Date ______________

History Review

Dentist Signature ______________________ Date ______________

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? ______________________________

____

Date of Last Dental Visit ______________ **Last Dental Cleaning** ______________ **Last Full Mouth X-rays** ______________

What was done at your last dental visit? ______________________________

____

Previous Dentist's Name ______________________________

Address ______________________________ State __________ Zip __________

Telephone ______________________________

How often do you have dental examinations? ______________________________

How often do you brush your teeth? ______________ How often do you floss? ______________

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) ______________________________

Do you have any dental problems now? Yes No

If yes, please describe: ______________________________

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? ______________

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause ______________

____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe ______________

Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe ______________________________

____

(Please complete other side)