Gary M. Verigin, DDS, Inc.
P.O. Box 128
1415 Oklahoma Avenue
Escalon, CA 95320-0128

Office: 209.838.3522
Fax: 209.838.2460
E-mail: info@biologicaldentalhealth.com

NEW CLIENT INFORMATION

Name _____ Date of birth _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

E-mail _____

Would you like to get our quarterly newsletter via e-mail? ☐ Yes ☐ No

Who may we thank for referring you to our office? _____

Do you have any allergies? ☐ Yes ☐ No

If yes, please list them.

_____

_____

Dental Insurance Company _____

Insurance Company Address _____

Name of Insurance Holder _____

Group # _____ Social Security # _____

In case of emergency, please notify my closest relative or friend not living with me:

Name _____

Relationship _____ Phone _____

Address _____

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Thank you for letting us help you in your quest for optimum health! To help us help you, please describe your reasons for seeking dentistry in our office. Be as specific as you can. If you need more space, use the back of this form or attach another sheet. We appreciate your taking the time to outline your needs and concerns.

Name _____ Date _____

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and consent to submission of my electronic signature.

Signature _____

HEALTH HISTORY - page 1

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name/phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

What types of therapy have you tried for this problem(s):

☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic
☐ acupuncture ☐ conventional drugs
other_____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major Hospitalizations, Surgeries, Injuries Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Check the level of stress you are experiencing on a scale of 1 to 10 (1 being lowest): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)? ☐ YES ☐ NO

If yes, please explain _____

☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations
☐ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Strong dislike for any one of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Do you: ☐ Prefer warmth (i.e., food, drinks, weather, etc.) ☐ Prefer cold (i.e., food, drinks, weather, etc.) ☐ No preference

Is your sleep disturbed at the same time each night? ☐ YES ☐ NO If yes, what time? _____

Time of day you feel the **most energy** or the **least symptoms**:

☐7 am - 9 am ☐9 am - 11 am ☐11 am - 1 pm
☐1 pm - 3 pm ☐3 pm - 5 pm ☐ 5 pm - 7 pm
☐7 pm - 9 pm ☐9 pm - 11 pm ☐11 pm - 1 am
☐1 am - 3 am ☐3 am - 5 am ☐ 5 am - 7 am

Time of day you **feel the worst** or your **symptoms are aggravated:**

☐7 am - 9 am ☐9 am - 11 am ☐11 am - 1 pm
☐1 pm - 3 pm ☐3 pm - 5 pm ☐ 5 pm - 7 pm
☐7 pm - 9 pm ☐9 pm - 11 pm ☐11 pm - 1 am
☐1 am - 3 am ☐3 am - 5 am ☐ 5 am - 7 am

HEALTH HISTORY - page 2

Name _____

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Bleeding	☐ Fecal incontinence
☐ Disinterest in sex	☐ Headaches	☐ Vomiting	☐ Discharge	☐ Urinary incontinence
☐ Disinterest in eating	☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash

Medical History

☐ Adrenal burnout
☐ Arthritis
☐ Allergies/hay fever
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Autoimmune disease
☐ Blood pressure problems
☐ Bronchitis
☐ Cancer
☐ Chronic fatigue syndrome
☐ Carpal tunnel syndrome
☐ Cholesterol, elevated
☐ Circulatory problems
☐ Colitis
☐ Dental problems
☐ Depression
☐ Diabetes
☐ Diverticular disease
☐ Drug addiction
☐ Eating disorder
☐ Epilepsy
☐ Emphysema
☐ Eyes, ears, nose, throat problems
☐ Environmental sensitivities
☐ Fibromyalgia
☐ Food intolerance
☐ Gastroesophageal reflux disease
☐ Genetic disorder
☐ Glaucoma
☐ Gout
☐ Heart disease
☐ HIV
☐ Infection, chronic
☐ Inflammatory bowel disease
☐ Irritable bowel syndrome
☐ Kidney or bladder disease
☐ Learning disabilities
☐ Liver or gallbladder disease (stones)
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological (Parkinson's, paralysis)
☐ Sinus problems
☐ Stroke
☐ Thyroid trouble
☐ Obesity
☐ Osteoporosis
☐ Pneumonia
☐ Sexually transmitted disease
☐ Seasonal affective disorder
☐ Skin problems
☐ Tuberculosis
☐ Ulcer
☐ Urinary tract infection
☐ Varicose veins
☐ Other _____

_____

Medical (Women)

☐ Menstrual irregularities
☐ Endometriosis
☐ Infertility
☐ Fibrocystic breasts
☐ Fibroids/ovarian cysts
☐ Premenstrual syndrome (PMS)
☐ Breast cancer
☐ Pelvic inflammatory disease
☐ Vaginal infections
☐ Decreased sex drive
☐ Sexually transmitted disease
☐ Other _____
Age of first period _____
Date of last gynecological exam ____
☐ Mammogram ☐ Pos ☐ Negative
☐ PAP ☐ Pos ☐ Negative
☐ Form of birth control _____
# of children _____
# of pregnancies _____
☐ C-section _____
☐ Surgical menopause
☐ Menopause
Date of last menstrual cycle _____
Length of cycle: _____ days
☐ Interval of time between cycles _____ days
☐ Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)
_____

Medical (Men)

☐ Benign prostatic hyperplasia (BPH)
☐ Prostate cancer
☐ Decreased sex drive
☐ Infertility
☐ Sexually transmitted disease
☐ Other _____
_____

Health Habits

Tobacco:
☐ Cigarettes: #/day _____
☐ Cigars: #/day _____
Alcohol:
☐ Wine: #glasses/d or wk _____
☐ Liquor: #oz/d or wk _____
☐ Beer: #glasses/d or wk _____
Caffeine:
☐ Coffee: #6 oz cups/d _____
☐ Tea: #6 oz cups/d _____
☐ Soda w/caffeine: #cans/d _____
☐ Other sources _____
☐ Water: #glasses/d_____

Family Health History (Parents and Siblings)

☐ Arthritis
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug addiction
☐ Eating disorder
☐ Genetic disorder
☐ Glaucoma
☐ Heart disease
☐ Infertility
☐ Learning disabilities
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological disorders (Parkinson's, paralysis)
☐ Obesity
☐ Osteoporosis
☐ Stroke
☐ Suicide
☐ Other _____
_____

Current Supplements

☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ EPA/DHA
☐ Evening Primrose/GLA
☐ Calcium, source _____
☐ Magnesium
☐ Zinc
☐ Minerals, describe _____
☐ Friendly flora (acidophilus)
☐ Digestive enzymes
☐ Amino acids
☐ CoQ10
☐ Antioxidants (e.g., resveratrol, lutein, etc.)
☐ Herbs - teas
☐ Herbs - extracts
☐ Chinese herbs
☐ Ayurvedic herbs
☐ Homeopathy
☐ Bach flowers
☐ Protein shakes
☐ Superfoods (e.g., bee pollen, phytonutrient blends)
☐ Liquid meals
☐ Other _____
_____

HEALTH HISTORY - page 3

Name _____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 min or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk
- ☐ Run, jog, jump rope
- ☐ Weight lift
- ☐ Swim
- ☐ Box
- ☐ Yoga
- ☐ Other _____

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction
- ☐ Specific food restrictions:
  - ☐ dairy ☐ wheat ☐ eggs
  - ☐ soy ☐ corn ☐ all gluten
- ☐ Other _____

Food Frequency

Servings per day:

- ☐ Fruits (citrus, melons, etc.) _____
- ☐ Dark green or deep yellow/orange vegetables _____
- ☐ Grains (unprocessed) _____
- ☐ Beans, peas, legumes _____
- ☐ Dairy, eggs _____
- ☐ Meat, poultry, fish _____

Eating Habits

- ☐ Skip breakfast
- ☐ Two meals/day
- ☐ One meal/day
- ☐ Graze (small frequent meals)
- ☐ Food rotation
- ☐ Eat constantly whether hungry or not
- ☐ Generally eat on the run
- ☐ Add salt to food

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

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Dental Questionnaire

Name _____ Date _____

Do you have any sores in your mouth? Acute or chronic pain in your teeth, gums, joints, head, face or neck? Where? For how long?

Have you ever had any teeth removed? Which ones? When? During removal, were you under IV sedation or general anesthetic? If so, why?

If you have had teeth removed, was there any infection prior to or following the procedure? Were antibiotics used before or after the surgery? If so, which ones?

YES	NO	
☐	☐	Do your gums ever bleed during flossing?
☐	☐	Do any of your teeth feel like they have loosened?
☐	☐	Do you think you have any "gum problems"?
☐	☐	Do you have any problems with receding gums?
☐	☐	Are any of your teeth sensitive to heat?
☐	☐	Are any of your teeth sensitive to cold?
☐	☐	Do you have any problems chewing food?
☐	☐	Do your teeth "fit together" as well as you'd like?
☐	☐	If no, do you think something should be done to make them "fit together" better?

Name _____

YES	NO	
☐	☐	Do you hear any noises in your jaw joints, just in front of your ears?
☐	☐	Do you ever have pain in these joints?
☐	☐	Do you have pain in the muscles that move your lower jaw?
☐	☐	Do you ever have spasms in these muscles?
☐	☐	Do you have any limitation of lateral (left/right) movement in your lower jaw?
☐	☐	Do you have any limitation of vertical (up/down) movement in your lower jaw?
☐	☐	Have you ever had any treatment for these joints?
☐	☐	Do you clench or grind your teeth while sleeping?
☐	☐	Do you clench or grind your teeth while awake?
☐	☐	Do you often get dizziness or vertigo?
☐	☐	Do you "gnash" your teeth while sleeping?
☐	☐	Do you "gnash" your teeth while awake?
☐	☐	If you answered yes to any of the last five questions, do you wear a splint?
☐	☐	Do you get more than just an occasional headache?
☐	☐	If yes, have you had chiropractic, dental or medical treatment for your headaches?

If yes, please explain:

_____

_____

☐	☐	If yes, are your headaches now under control?
☐	☐	Are you allergic, sensitive or reactive to any dental anesthetics?
☐	☐	Are you allergic, sensitive or reactive to any dental materials?
☐	☐	Have you ever had dental material reactivity testing done prior to restorative dentistry?
☐	☐	Do you have any root canal filled teeth in your mouth?
☐	☐	Do you have any teeth that have been recommended for root canals?
☐	☐	Are you familiar with the term "jawbone cavitations"?
☐	☐	If so, do you think you might have jawbone cavitations?
☐	☐	Have you been previously evaluated for jawbone cavitations?

If yes, please tell us who evaluated you, when, and what was found:

_____

_____

Please let us know anything else you think will help us best understand your dental needs and concerns:

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and consent to submission of my electronic signature.

Signature _____

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PREVIOUS TREATING CAREGIVERS

Please list ALL practitioners you have seen for your current problem. This information is essential. Include physicians, dentists, chiropractors, psychologists, physical therapists, neurologists, homeopaths, naturopaths and all other clinicians.

Begin with the most recent and list in reverse chronological order. End with your first emergency room visit, if applicable. For each, briefly describe why you were seen (diagnosis) and what was done for the problem (treatment, including x-rays, medications and referrals).

Also tell us about the success of these treatments, rating each from 1 to 10, with 10 being "very successful" and 1, "not at all successful."

Please be complete. If incomplete, you may be charged an extra visit fee, due to staff time needed to get this information. If you need more room, please attach an extra sheet. **Please print.**

Name _____ Date _____

1. Practitioner _____ Specialty _____

Address _____ Phone _____

Date(s) of treatment: _____ Treatment Success Rating: _____

Diagnosis and treatment:

2. Practitioner _____ Specialty _____

Address _____ Phone _____

Date(s) of treatment: _____ Treatment Success Rating: _____

Diagnosis and treatment:

continued

Name _____

3. Practitioner _____ Specialty _____

Address _____ Phone _____

Date(s) of treatment: _____ Treatment Success Rating: _____

Diagnosis and treatment:

4. Practitioner _____ Specialty _____

Address _____ Phone _____

Date(s) of treatment: _____ Treatment Success Rating: _____

Diagnosis and treatment:

5. Practitioner _____ Specialty _____

Address _____ Phone _____

Date(s) of treatment: _____ Treatment Success Rating: _____

Diagnosis and treatment:

Name _____

Signs & Symptoms of Sensitivity or Toxicity to Mercury or Other Harmful Substances

YES	NO	Don't Know		
				Local/Intraoral
☐	☐	☐	1.	Do you have 6 or more "silver" amalgam fillings?
☐	☐	☐	2.	Do you often have a metallic taste in your mouth?
☐	☐	☐	3.	Do the metals in your jewelry cause any skin breakouts or leave a blackish coloration?
☐	☐	☐	4.	Have you often had sore gums (gingivitis) over the years?
☐	☐	☐	5.	Has ringing in your ears (tinnitus) been a problem?
☐	☐	☐	6.	Have TMJ (temporal mandibular joint) problems been of concern?
☐	☐	☐	7.	Do you often have bad breath (halitosis) or white tongue (thrush)?
☐	☐	☐	8.	Does your tongue ever feel swollen or have scalloped edges?
☐	☐	☐	9.	Do you have any dark tattooing on your gums?
☐	☐	☐	10.	Do you have any white spots or growths inside your mouth?
				Psychological
☐	☐	☐	11.	Have you had mental symptoms such as confusion or forgetfulness?
☐	☐	☐	12.	Has severe depression been a frequent problem?
☐	☐	☐	13.	Do you ever feel like you don't have the ability to make good decisions?
☐	☐	☐	14.	Do you have problems with remembering recent events or names?
☐	☐	☐	15.	Have you been to many doctors for your health problems and been told there is "nothing wrong" with you?
☐	☐	☐	16.	Is your sleep poor or do you have frequent insomnia?
☐	☐	☐	17.	Do you experience irritability or dramatic changes in behavior?
☐	☐	☐	18.	Are you on antidepressants now or have been in the past?
				Neurological
☐	☐	☐	19.	Have you had unusual shakiness (tremors) of your hands or arms, or twitching of other muscles?
☐	☐	☐	20.	Do you have numbness or unexplained tingling in your arms or legs?
☐	☐	☐	21.	Have you developed difficulty in walking (ataxis) over the years?
☐	☐	☐	22.	Do you have unexplained muscle pain?
☐	☐	☐	23.	Are you plagued with more headaches than you think you should have?
☐	☐	☐	24.	Do you have any vision problems or notice your field of vision is diminishing?
				Immunological/Autoimmune
☐	☐	☐	25.	Do you have "brown spots" or "age spots" under your eyes or elsewhere on your skin?
☐	☐	☐	26.	Have you tended to have more colds, flu, or other infectious diseases than "normal"?
☐	☐	☐	27.	Do you have unexplained arthritis in various joints?
☐	☐	☐	28.	Do you have problems with your sinuses?
☐	☐	☐	29.	Do you ever get long term swelling in the lymph nodes down the side of your neck or under your jaw?
☐	☐	☐	30.	Is your total white blood cell count below 3000 or above 8000?
☐	☐	☐	31.	In your white blood cell count, is the lymphocyte percentage below 20% or above 55%?

Signs & Symptoms of Sensitivity or Toxicity to Mercury or Other Harmful Substances

YES	NO	Don't Know		
				Gastrointestinal
☐	☐	☐	32.	Have you taken any antibiotics or steroidal medicines within the last 4 years?
☐	☐	☐	33.	Have you had food allergies or intolerances?
☐	☐	☐	34.	Have you ever had Candida-Related Complex (CRC) or yeast infections in your GI tract?
☐	☐	☐	35.	Do you have problems with constipation and or diarrhea?
☐	☐	☐	36.	Do you have any irritable or Colitis symptoms?
☐	☐	☐	37.	Is it common for you to have a lot of mucus in your stool?
				Environmental
☐	☐	☐	38.	Have you ever worked as a painter or in the manufacturing/chemical/pesticide/ fungicide field or in pulp/paper mills?
☐	☐	☐	39.	Have you ever worked as a dentist, hygienist, or dental assistant?
☐	☐	☐	40.	Have you worked with chemicals such as benzene or acetones?
☐	☐	☐	41.	Do you garden and use sprays like Roundup?
				Endocrine
☐	☐	☐	42.	Have you frequently had low basal body temperature (<97.4º F) over the years?
☐	☐	☐	43.	Do you feel like your hands and feel are cold more than they should?
☐	☐	☐	44.	Are you extremely fatigued most of the time and never seem to have enough energy?
				Cardiovascular
☐	☐	☐	45.	Do you have heart irregularities or rapid pulse (tachycardia)?
☐	☐	☐	46.	Do you have unidentified chest pains even after EKGs, x-rays, and heart studies are normal?
				Urogenital
☐	☐	☐	47.	Have you ever had Candida-Related Complex (CRC) or yeast infections?
☐	☐	☐	48.	Have you had frequent kidney infections or do you have significant kidney problems?

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Biological Client Disclaimer and Informed Consent Statement

I have chosen the services I have asked to be performed on me, and I have done so based on my beliefs and awareness of the relevant scientific documentation, some of which I have found on the Internet. Other material has been recommended by my referring medical health providers or provided by Dr. Gary Verigin. Dr. Verigin has offered me the full range of opinions and options. We have thoroughly discussed all treatment possibilities. I have been able to consult with my physician about the procedures I have chosen.

I understand that Dr. Verigin is a mercury-free dentist, not a medical doctor or practitioner. He does not claim that mercury-amalgam, root canals or cavitations cause specific diseases. He does not claim that specific health problems will be cured or relieved by amalgam or tooth removal, or the elimination of cavitations. He has neither recommended nor attempted to influence me toward any of these three particular procedures.

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and consent to submission of my electronic signature.

Signature - Type your name _____

Date _____

Counselor _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

E-mail _____

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Nutritional Client Statement

I confirm the following:

On this and all subsequent visits, I am here on my own behalf. I am not an agent for federal, state or local agencies on a mission of investigation or entrapment.

I fully understand that Gary M. Verigin, DDS, is not a medical doctor or practitioner. I am not seeking medical diagnosis or treatment from him or any member of his staff.

The services performed by Gary M. Verigin, DDS, inc., are always restricted to consultation on nutritional matters. They are solely for the purpose of maintaining the best state of nutritional health. They do not involve the diagnosis, prognostication or prescription of remedies for the treatment of any diseases, including my present health conditions.

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and consent to submission of my electronic signature.

Signature - Type your name _____

Date _____

Counselor _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

E-mail _____

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Notice of Privacy Practices
Client Acknowledgement

Name: _____ Date of birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. I understand that the Notice explains how my protected health information may be used and both my rights and this practice's legal duties with respect to its use. The Notice includes:

- A statement that this practice, by law, must respect the privacy of protected health information
- A statement that this practice must follow the terms of the Notice
- The ways in which this practice is allowed to use my protected health information with respect to treatment, payment and health care operations
- Descriptions of any other ways in which this practice must or is allowed to use my protected health information without my written consent
- A description of uses that are prohibited or limited by law
- A description of other uses that can be made only with my written consent, which I may revoke at any time
- My rights with respect to my protected health information and a brief description of how I may exercise them, including:

    - The right to complain to this practice and the Secretary of Health and Human Services if I believe my privacy rights have been violated, with no retaliatory actions taken against me if I make complaint
    - The right to ask for restrictions on certain uses of my protected health information, understanding that this practice is not required to agree
    - The right to receive confidential communications of my protected health information
    - The right to inspect and copy my protected health information
    - The right to correct errors in my protected health information
    - The right to know of any disclosures of my protected health information
    - The right to get a paper copy of the Notice of Privacy Practices from this practice upon request

I understand that this practice reserves the right to change the terms of its Notice that may apply to all of my protected health information that it maintains.

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and consent to submission of my electronic signature.

Signature - Type your name _____ Date _____

Relationship to client (if signed by a personal representative of the client): _____