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

Office: 209.838.3522
Fax: 209.838.2460
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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 ____