

WELCOME TO OUR OFFICE

Please take a moment to provide us with the requested information. This is necessary for us to better address your dental needs.

Name: _____ Date of birth: _____
Address: _____ City: _____ Zip: _____
Email Address: _____ Height: _____ Weight: _____
Phone Number: _____ Sex/gender: _____
Place of Work/Occupation: _____ Marital status: _____
Name(s) of Spouse/Dependents: _____
Do you have dental insurance: Y N Insurance Name : _____
Social Security Number (needed for most insurances): _____
How did you hear about us? _____ What is the purpose of this visit? _____

• MEDICAL HISTORY •

Have you been hospitalized in the past two years? Y N If yes, what was the reason? _____
Have you been under the care of a physician in the past two years? Y N If yes, what is/was the reason? _____
Are you currently taking any prescription drug(s)? Y N If yes, which one(s) (name & dosage) _____
Are you allergic to **PENICILLIN** or **ANY OTHER DRUG(S)**? Y N If yes, which one(s)? _____

Have you ever had any excessive bleeding requiring treatment? Y N

Please mark any of the following you are or have experienced:

- | | | | | |
|---|---|--|---|---|
| ☐ Blood thinner use* | ☐ Joint replacement* | ☐ Asthma | ☐ Herpes | ☐ Hepatitis |
| ☐ Artificial heart valve* | ☐ Artificial implant* | ☐ Diabetes | ☐ HIV/AIDS | ☐ Kidney Disease |
| ☐ Cardiac pacemaker | ☐ Stroke | ☐ Epilepsy/seizures | ☐ Anemia | ☐ Sinus trouble |
| ☐ Bisphosphonate use* | ☐ Osteoporosis | ☐ Cancer treatment | ☐ Persistent cough | ☐ Psychiatric tx |
| ☐ High blood pressure | ☐ Heart murmur | ☐ Food allergies: _____ | | |

Have you had any other serious illness, condition, or procedure not listed above? _____

*** For these conditions, do you take or have you been instructed to take premedication prior to dental treatment? Y N**
If yes, which medication(s) (name & dosage): _____

If female, are you pregnant? Y N Do you smoke? Y N Pack(s) per day _____ # years _____

• DENTAL HISTORY •

Do you brush daily? Y N Do you floss daily? Y N Do your gums bleed? Y N
Date of last dental treatment: _____ What was done? _____
Do you currently have any dental concerns? _____

I give Dr. A. DeFilippo, Dr. R. Rushin, or Dr. J. DeFilippo permission to examine and treat me Y N or any dependent Y N according to their best judgment. I will cooperate fully in these matters. _____ (initials)

I understand that I am ultimately responsible for any fees for services rendered. Any balances past 90 days may be subject to an 18% annual interest charge and 15% collection fee. If outside agencies are necessary to help collect the balance, I am responsible for any costs incurred, including reasonable attorney's fees.

Patient Signature: _____

Reviewed by (office use only): _____ Date: _____

