WELCOME TO OUR OFFICE THANK YOU FOR CHOOSING US. DATE _____

PATIENT INFORMATION

Minor____ Single ____ Married ____ Widowed ____ Divorced ____

Name _____ Date of Birth _____ SS#_____

Address _____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ E-mail Address_____

Occupation_____ Employer_____ Work Phone_____

If Student, Name of School/College/State_____

Whom may we thank for referring you to us? _____

Name of nearest relative NOT living with you._____ Telephone_____

Do You Speak English? YES NO. If no name of translator that must be present at ALL appointments.

_____Telephone_____

DENTAL INSURANCE INFORMATION

Insurance Company Name/Address _____

Insurance Group Number_____

Subscriber Name & SS Number (Person Who Has Dental Contract) _____

_____

I hereby authorize Dr. D'Angelo to release to your company any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care. I authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for dental treatment by reason of such treatment or services rendered to:

Patient Name _____

Signature of Insured_____ Date_____

RESPONSIBLE PARTY

Name of person financially responsible for this account_____

Relationship_____ Address (if different than above)_____

_____

DOB of responsible party_____ SS# of responsible party_____

I understand and agree that regardless of my insurance benefit, I am ultimately responsible for any payments due on this account.

Signature of responsible party _____ Date _____

Please Turn Over & Complete Back ☛

HEALTH HISTORY

Family Doctor Name _____

List Any Medications you are currently taking _____

_____

_____

List Any Allergies you have including latex_____

_____

CIRCLE YES / NO IF YOU HAVE OR EVER HAD:

HEART DISEASE/SURGERY	YES	NO	THYROID DISEASE	YES	NO
PACEMAKER/ANGINA	YES	NO	STROKE	YES	NO
DIABETES	YES	NO	ASTHMA/LUNG PROBLEM	YES	NO
LOW BLOOD PRESSURE	YES	NO	EATING DISORDERS	YES	NO
HIGH BLOOD PRESSURE	YES	NO	VENEREAL DISEASE	YES	NO
CANCER.....TYPE	YES	NO	SINUS PROBLEMS	YES	NO
HIV POSITIVE	YES	NO	USE TOBACCO	YES	NO
HEPATITIS A B C circle	YES	NO	JOINT REPLACEMENT	YES	NO
RECENT BLOOD TRANSFUSION	YES	NO	BIRTH CONTROL..PILLS...PATCH	YES	NO
DRUG ADDICTION/ABUSE	YES	NO	PREGNANT	YES	NO
RHEUMATIC FEVER	YES	NO	OSTEOPOROSIS	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	CHEMOTHERAPY	YES	NO
HEART MURMUR	YES	NO	FAINTING/DIZZINESS	YES	NO

REQUIRE ANTIBIOTIC PRIOR TO DENTAL TREATMENT ?.....NAME OF ANITBIOTIC.....YES NO

OTHER MEDICAL CONDITIONS NOT LISTED_____

_____

HEALTH HISTORY REVIEWED WITH DOCTOR _____

Signature DATE

DENTAL HISTORY

Do you have any specific concerns at this time? _____

Are you interested in whiter teeth? YES NO

Would you like a complete smile make over? YES NO

Is there anything you would like to change about your teeth or smile ?_____

_____

_____

I UNDERSTAND THAT THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE. IF THERE IS A CHANGE IN MY HEALTH STATUS I WILL REPORT IT.

Patient Signature _____

Date _____