# Larry Adatto

THE EXCEPTIONAL SMILE EXPERIENCE

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The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

## 1 PATIENT INFORMATION

Date _____

Name _____

E-mail Address _____

I prefer to be called _____ ☐ Male ☐ Female

Birthday _____ Age _____ SS # _____

Home Address _____

_____

☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated ☐ Partnered

Hm # _____ Cell # _____

Wk # _____ Ext. _____ DL # _____

Employer _____

Employer Address _____

Occupation _____

Where & when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family member seen by us _____

Present / Previous Dentist _____

Last visit date _____

## 2 SPOUSE INFORMATION

Name _____

Employer _____

Email Address _____

Cell # _____ Birthday _____

Person responsible for account _____

Wk # _____ Ext. _____ Home # _____

Email Address _____

Billing Address _____

Relation _____ SS # _____

Employer _____ DL # _____

## 3 INSURANCE COVERAGE

PRIMARY

Dental Coverage ☐ Yes ☐ No

Insurance Co. Name _____

Address _____

Phone _____

Group #, Plan, Local or Policy # _____

Insured's Name _____ Relation _____

Insured's Birthdate _____ Insured's ID # _____

Insured's Employer _____

SECONDARY

Dental Coverage ☐ Yes ☐ No

Insurance Co. Name _____

Address _____

Phone _____

Group #, Plan, Local or Policy # _____

Insured's Name _____ Relation _____

Insured's Birthdate _____ Insured's ID # _____

Insured's Employer _____

## 4 PERSONAL CONTACT INFO

In the event of an emergency, is there someone who lives near you that we should contact?

Name _____ Relation _____

Cell# _____ Hm# _____

## 5 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone # _____ Date of last visit? _____

Are you currently under the care a physician? ☐ Yes ☐ No

Please explain _____

## 6 MEDICAL HISTORY

Your current physical health is? ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ☐ | ☐ | Abnormal Bleeding | ☐ | ☐ | Hepatitis |
| ☐ | ☐ | Alcohol / Drug Abuse | ☐ | ☐ | Herpes / Fever Blisters |
| ☐ | ☐ | Anemia | ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Arthritis | ☐ | ☐ | HIV* / AIDS |
| ☐ | ☐ | Artificial Bones / Joints / Valves | ☐ | ☐ | Hospitalized for any Reason |
| ☐ | ☐ | Asthma | ☐ | ☐ | Kidney Problems |
| ☐ | ☐ | Blood Transfusion | ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Cancer Chemotherapy | ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Colitis | ☐ | ☐ | Mitral Valve Prolapse |
| ☐ | ☐ | Congenital Heart Defect | ☐ | ☐ | Pacemaker |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Psychiatric Treatment |
| ☐ | ☐ | Difficulty Breathing | ☐ | ☐ | Radiation Treatment |
| ☐ | ☐ | Emphysema | ☐ | ☐ | Rheumatic / Scarlet Fever |
| ☐ | ☐ | Epilepsy | ☐ | ☐ | Seizures |
| ☐ | ☐ | Fainting Spells | ☐ | ☐ | Shingles |
| ☐ | ☐ | Frequent Headaches | ☐ | ☐ | Sickle Cell Disease / Traits |
| ☐ | ☐ | Glaucoma | ☐ | ☐ | Sinus Problems |
| ☐ | ☐ | Hay Fever | ☐ | ☐ | Stroke |
| ☐ | ☐ | Heart Attack | ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | Heart Murmur | ☐ | ☐ | Tuberculosis (TB) |
| ☐ | ☐ | Heart Surgery | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Hemophilia | ☐ | ☐ | Venereal Disease |

Please list any serious medical condition (s) that you have ever had

_____

_____

Are you allergic to any of the following?

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Aspirin | ☐ | ☐ | Erythromycin | ☐ | ☐ | Metals |
| ☐ | ☐ | Codeine | ☐ | ☐ | Jewelry | ☐ | ☐ | Penicillin |
| ☐ | ☐ | Dental Anesthetics | ☐ | ☐ | Latex | ☐ | ☐ | Tetracycline |

Please list any other drugs / materials that you are allergic to _____

_____

## 7 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TJM / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Are you concerned about any crooked teeth? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover.

_____

Signature Date

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments _____

_____

_____

MEDICAL HISTORY UPDATE

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____