

HEALTH AND DENTAL HISTORY FORM

Dr Marie Calabrese

PATIENT INFORMATION

Patient Name: _____ Date: ___ / ___ / ___
Last First MI (Preferred Name)
 Gender > Male Female Family Status > Minor Single Married Divorced Widowed Separated
 Social Security # (if you have ins.): _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ (Mobile) _____
 Address: _____
Street Apartment #

City State Zip Code
 E-Mail Address _____ Last dental visit date ___ / ___ / ___
 How were you referred to our practice: _____
 Reason for this visit? _____
 If you could change anything about your smile, what would you change? _____

Have you ever had any complications following dental treatment? Yes No

If yes, please explain _____

*** If patient is not financially responsible (i.e Child) we need parent or responsible party information ***

The following is for: the patient's spouse the patient's parent or guardian the person responsible for payment

Name: _____
 Male Female Married Single Other
 Social Security #: (if you have ins.) _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ (Mobile) _____
 Address: _____
Street Apartment #

City State Zip Code

EMPLOYMENT INFORMATION

The following is for: Parent or guardian Other (relationship) _____ * for person responsible for payment
 Employer Name: _____ Occupation: _____
 Address: _____
Street City, State Zip Code Phone

Fill out the below information only if you have Dental Insurance or if different from above.

INSURANCE INFORMATION

(Only if you have DENTAL insurance)

Primary Insurance Plan Name / Address: _____

 Name of Insured (person): _____ Is insured a patient? Yes No
Last First MI
 Insured's Birth Date: _____ ID #: _____ Group #: _____
 Insured's Address: _____
Street City State Zip Code
 Insured's Employer Name: _____
 Address: _____
Street City State Zip Code
 Patient's relationship to insured: Self Child Spouse Other _____

(If you have secondary DENTAL insurance let us know)

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Have you ever had any of the following? Please check those that apply:

- Allergies to:
- Dental Anesthetic
- Codeine Allergy
- Penicillin Allergy
- Allergy other med.

- Seasonal Allergy
- Environmental Allergy
- Latex / rubber Allergy
- Other Allergy

- AIDS
- Artificial Joints
- Asthma
- Blood Disease
- Cancer / Tumors
- Diabetes
- Dizziness
- Epilepsy / Seizure
- Excessive Bleeding
- Fainting
- Glaucoma
- Growths
- Headache / Migraine
- Head Injuries
- Heart Disease
- Heart Murmur
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease

- Mental Health Care
- Anxiety Disorders
- Pacemaker
- Pregnancy
Due date: _____
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stomach Problems
- Stroke
- Tuberculosis
- Ulcers
- STD

Describe any :
Tobacco use -----
_____ / day or wk

Alcohol -----
_____ / day or wk

Soft Drinks -----
_____ / day or wk

Coffee / Tea ----
_____ / day or wk

Ounces of water -----
_____ / day or wk

Is your water fluoridated? (circle one)
Yes / No / Don't know

Is your diet medically supervised? (circle one)
Yes / No

Any unexplained change in weight? (circle one)
Yes / No

Dental Questions

How often do you brush your teeth?

_____ times / day
_____ times / week

How often do you floss your teeth ?

_____ times / day
_____ times / week
_____ times / month

Do your gums bleed when you brush or floss your teeth ? Yes / No

Are your teeth sensitive to: Hot / Cold / Sweet / Sour / Pressure / None (circle any)

Are you especially anxious or fearful about dentistry ? Yes / No

Do you have any jaw: pain / clicking / locking (circle any)

Have you had an injury to your head, neck or jaw ? Yes / No

Do you wear retainers, night guard or other appliance? Yes / No

Have you ever lost any teeth? Yes / No

Age of current partial or denture _____

Any mouth odor or unpleasant taste? Yes / No

Have you ever had any:
 Periodontal treatment
 Orthodontic treatment
 Clenching / Grinding

Name of Physician: _____ Phone: _____

Do you have any other health problems that you would like to talk to the Doctor about? Yes No

List all Medications you are presently taking including herbal medications, vitamins, etc.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature _____ Date: _____

Consent for Services

All emergency dental services performed without previous financial arrangements, must be paid for in full at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any balance due is the patient's responsibility. For children, regardless of custody or child support arrangements, it is the policy of this office that the parent who brings the child to the office for treatment is responsible, in full, for fees for services rendered or any balance remaining after insurance payments. I grant my permission to your office to telephone me to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment / responsible party _____ Date: _____