WELCOME TO OUR OFFICE

Please take a minute to provide us with the requested information. It is necessary for our records and will help us to better address your dental needs.

Name:_____Today's date:_____
Street:_____City:_____Zip:_____
Home phone:_____ Work phone: _____
Cell phone: _____ Soc. Sec. # _____
Date of birth:_____Sex:_____Height:_____Weight:_____
Place of work:_____Occupation:_____
Marital status:_____Names of spouse & dependents:_____
_____
Whom may we thank for referring you?_____
Do you have dental insurance?_____What company?_____
If not, who is responsible for this account?_____
What is the purpose of this visit?_____

MEDICAL HISTORY:
Have you been a patient in a hospital during the past 2 years?_____
If so, what for?_____
Have you been under the care of a physician during the past 2 years?____
If so, what for?_____
Have you taken any kind of medicine or drugs during the past year?_____
Name of drug(s)_____
ARE YOU ALLERGIC TO PENICILLIN OR ANY OTHER DRUGS OR MEDICINE?_____
Which ones?_____
Have you ever had excessive bleeding requiring treatment?_____
Have you ever had a blood test for hepatitis?_____
Circle any of the following which you have had or now have:

HIV virus (AIDS)	allergies	anemia
arthritis	artificial heart valves	asthma
cancer treatment	cardiac pacemaker	persistent cough
diabetes	epilepsy	heart murmur
heart disease	hepatitis	herpes
high blood pressure	jaundice	kidney treatment
psychiatric treatment	sinus trouble	stroke
tuberculosis	artificial implant	

Have you had any other serious illness?_____
If female, are you pregnant now?_____
Do you smoke?_____Pack(s) per day:_____How many years?_____
Do you drink coffee or tea?_____Cups per day:_____

DENTAL HISTORY:
Do you brush your teeth daily?_____Floss daily?_____
Do your gums bleed?_____When was last dental treatment?_____
What was done?_____
Please list any other dental concerns:_____

I give Dr. DeFilippo/Rushin my permission to examine and treat me ( ), my child ( ), my dependent ( ) according to their best judgement. I will cooperate fully in these matters.

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

Signature_____

Reviewed_____Date_____