Patient Information

Patient Name:______________________________ Date:__________________

Social Security#:________________________ Birth Date:________________

Address:____

Phone (Home):________________ (Work):______________ (Cell):___________

Responsible Party Information

Name:____

( ) Male ( ) Female ( ) Married ( ) Single ( ) Parent ( ) Other_________________

Social Security #:_______________________ Birth Date:_________________

Address:____

Phone (Home):_______________ (Work):______________ (Cell):____________

Employment Information

Employer Name:__________________________ Occupation:_________________

Address:____

Insurance Information

Primary Insurance Plan Name____

Subscriber's Name____________________________ Birth Date:_______________

ID#:_____________________ Group#:______________

Secondary Insurance Plan Name____

Subscriber's Name__________________________ Birth Date:_________________

ID#:_____________________ Group#:______________

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services at the time that they are rendered.

Preferred Method of Payment ( ) Cash ( ) Check ( ) Credit Card

Signature of Patient or Responsible Party___________________________________

Whom may we thank for referring you____

HEALTH HISTORY PLEASE CIRCLE

1) Are you in good health?.......................................YES NO
2) Has there been any change in your general health within the past year?.......................................YES NO
3) My last physical examination was on ______________
4) Physician's name and address ______________
____
____
5) Are you now under the care of a physician?..................YES NO
a) If so, what condition is being treated?______________
6) Have you had any serious illness or operation?............YES NO
a) If so, what? ______________
7) Do you have or have you had any of the following:

Tire easily, weakness......	YES	NO	Rheumatic fever..........	YES	NO
Marked weight change.......	YES	NO	Heart Murmur.............	YES	NO
Night sweats...............	YES	NO	Chest pain/discomfort....	YES	NO
Persistent fever...........	YES	NO	Heart attack/trouble.....	YES	NO
			Shortness of breath......	YES	NO
Eruptions (rash) hives.....	YES	NO	Swelling of ankles.......	YES	NO
Change in skin color.......	YES	NO	High blood pressure......	YES	NO
Visual change..............	YES	NO	Congenital heart disease.	YES	No
Glaucoma...................	YES	NO	Artificial heart valve...	YES	NO
Loss of hearing............	YES	NO	Pacemaker................	YES	NO
Ringing of ears............	YES	NO	Heart surgery............	YES	NO
			Other....................	YES	NO
Frequent nose bleeds.......	YES	NO			
Sinus trouble..............	YES	NO	Arthritis................	YES	NO
Persistent throat soreness/hoarseness...	YES	NO	Artificial joints........	YES	NO
			Rheumatism...............	YES	NO
Stroke.....................	YES	NO	Hepatitis................	YES	NO
Frequent headaches.........	YES	NO	Jaundice.................	YES	NO
Convulsions/epilepsy.......	YES	NO	Kidney disease...........	YES	NO
Numbness/tingling..........	YES	NO	Liver disease............	YES	NO
Dizziness/fainting.........	YES	NO	Ulcers...................	YES	NO
Psychiatric treatment......	YES	NO			
			Bruise easily............	YES	NO
Tuberculosis...............	YES	NO	Anemia...................	YES	NO
Emphysema..................	YES	NO	Other blood disorder.....	YES	NO
Asthma/hay fever...........	YES	NO	Blood transfusion........	YES	NO
Persistent cough...........	YES	NO			
Cough up blood.............	YES	NO	Radiation therapy........	YES	NO
			HTLV virus (Aids virus)..	YES	NO
Diabetes...................	YES	NO	Tumor or growth..........	YES	NO
Thyroid condition..........	YES	NO	Cancer...................	YES	NO

(over)

If patient is a child: Is child taking fluoride vitamins? Yes No

8) Are you **ALLERGIC** or have you reacted adversely to:

Local anesthetics (e.g. novocaine)	Yes	No	Aspirin	Yes	No
Penicillin	Yes	No	Codeine	Yes	No
Other antibiotics	Yes	No	Other narcotics	Yes	No
Sulfa Drugs Yes	Yes	No	Barbiturates/Sedatives/ Sleeping pills	Yes	No

* Other allergies including food, metals, adhesive tape, etc.________________

____

9) Are you taking any of the following **DRUGS** or **MEDICATIONS**?

Antibiotics	Yes	No	Tranquilizers	Yes	No
Blood Thinners	Yes	No	Insulin	Yes	No
Blood Pressure Medications	Yes	No	Other Diabetic Drugs	Yes	No
Thyroid Meds.	Yes	No	Digitalis	Yes	No
Cortisone/Steroids	Yes	No	Nitroglycerin	Yes	No
Antihistamines/ Allergy Drugs	Yes	No	Other heart drugs	Yes	No
			Cold Remedies	Yes	No
			Aspirin	Yes	No

OTHER________________

*If Yes to any of the above, list **NAME** and **DOSAGE** of medication.

____

____

10) Is there any disease, condition, or problem not listed above that you think we should know about, or is there an activity your doctor says you cannot do? If YES, explain.

____

____

11) Have you ever had any serious trouble associated with previous dental treatment?

____

12) If female, are you pregnant? Yes No

To the best of my knowledge, all the preceding answers are correct.

If I ever have any change in my health or medication, I will inform Dr. Riccobono/Dr. Cohn at my next appointment.

Signature of Patient, Parent, or Guardian ______________________ Date__________

Dr. Riccobono D.D.S.: ______________________ Date__________

Dr. Viki Cohn D.D.S.: ______________________ Date__________