WELCOME TO OUR OFFICE

In order to render optimum health service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency.

PLEASE ANSWER EVERY QUESTION ON BOTH SIDES.

PERSONAL INFORMATION

Patient's Name ______________ Today's Date ______________ (Day Month Year)

Address ______________ Date of Birth ______________ Age ______

City ______________ Home Phone ______________

Postal Code ______________ Office Phone ______________

Occupation ______________ Sex ______ Marital Status ______________

Name of Employer ______________ Medical Doctor ______________

Name of person responsible for this account (if under the age of 16) ______________

Do you have dental insurance? ☐ Yes ☐ No

Actual Subscribers Name ______________ Birthdate ______________

Insurance Company Name ______________

Policy No. ______________ Certificate No. ______________

General Dentist ______________ Referred by ______________

Emergency Contact: ______________ Phone No. ______________

MEDICAL HISTORY

YES NO

1. Have you had a recent illness, operation, been hospitalized or under the care of a physician? ☐ ☐
   If yes, explain ______________
2. Are you presently taking any medicines, drugs, or pills? ☐ ☐
   If yes, explain ______________
3. Do you have or have you ever had any of the following? (Circle)

Rheumatic Fever	Kidney Disease	Thyroid Disease
Heart Trouble	Diabetes	Lung Disease
High Blood Pressure	Epilepsy	Asthma
Heart Murmur	Radiation or Chemo Therapy	Blood Disorders/Anemia
Psychiatric Problems	Gastrointestinal Disease	Anxiety/Panic Attack
Neurological Disorders	HIV/Immuno Suppression	Cancer
Liver Disease (Jaundice, Hepatitis)	Fibromyalgia	Sinusitis Arthritis

   Other ______________
4. Do you have any allergies to any foods, medication, material e.g. latex, antibiotics? ☐ ☐
   If yes, explain ______________
5. Have you ever had freezing (local anaesthetic) in your mouth? ☐ ☐
   Any ill effects from it? ______________

Over

6. Have you reacted adversely to any of the following? YES NO
   - Penicillin or other antibiotics? ☐ ☐
   - Sedatives, valium or sleeping pills? ☐ ☐
   - Aspirin, Ibuprofin? ☐ ☐
   - Codeine? ☐ ☐
   - Other? ______________
7. Do you bleed abnormally, bruise easily, have fainted before or have experienced shortness of breath? ☐ ☐
8. Is there anything that the dentist should know regarding your medical history that has not been mentioned? ☐ ☐
   If yes, explain ______________
9. To the best of your knowledge, are you in good health? ☐ ☐
   WOMEN: Are you pregnant? ☐ ☐
   If yes, in what stage of pregnancy? ______________

DENTAL HISTORY

1. Have you ever been a patient here? ☐ ☐
2. Are you having pain? **Yes** ☐ **No** ☐ Hot Cold Bite Touch
3. Is there swelling or pressure? ☐ ☐
4. Do you have or have you had panic attacks/anxiety attacks at any dental appointments? ☐ ☐
5. Do you gag easily at dental appointments? ☐ ☐
6. Are you claustrophobic? ☐ ☐
7. What is your present dental problem? ______________
   Did you receive a prescription for your present dental problem? ☐ ☐
   If yes, what was prescribed? ______________

OFFICE POLICY (Please Read)

1. Regarding insurance: All professional services are CHARGED DIRECTLY TO THE PATIENT and PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THEIR ACCOUNTS. We will prepare any necessary forms or reports to help collect your benefits from insurance companies.
2. Please help us to maintain the operations of our office on sound principles so that we may assure you and other patients uninterrupted treatment. Remember that once you have made an appointment this time is reserved for you; therefore at least 48 hours NOTICE must be given if cancellation is absolutely necessary. If notice is not given a cancellation fee may be charged.
3. Office policy is that services are paid for at each visit as they are performed.
4. I have read and understand the collection and use of information for Dr. Delle Donne's office in order to process insurance claims, reports and letters.
5. Patient's/Guardian's signature ______________

UPDATE

1. Date ______________ Change ______________
2. Date ______________ Change ______________