PATIENT INFORMATION FORM

Name (Last) (First) (Middle)				Date	Patient No.
Name (Last) (First) (Middle)				Home Telephone No.	Cell Phone No.
Home Address				Business Name	
City	State		Zip Code	Business Address	
Date of Birth	Sex	Height	Weight	Business Phone No.	Email Address:
Marital Status:	Social Security No.			In Case of Emergency: Name and Telephone No.	
Spouse / Parent : Name and Telephone No.				Referred By:	Best Way to Contact You:

Dental Insurance Information (Primary Carrier)			Dental Insurance Information (Secondary Carrier)		
Insured's Name (Last) (First) (Middle)			Insured's Name (Last) (First) (Middle)		
Insurance Company			Insurance Company		
Insurance Company Address			Insurance Company Address		
Insured's Employer			Insured's Employer		
Insured's Soc. Sec. No.	ID No.	Group No.	Insured's Soc. Sec. No.	ID No.	Group No.

Health History

Physician's Name	Phone No.	Address	
Date of Last Physical	Blood Pressure	Pulse	Are you Pregnant?

Are you allergic or have you experienced any reaction to the following?

	Yes	No		Yes	No		Yes	No
Local Anesthetics (e.g. Novocain)………….…	☐	☐	Aspirin..……………………………..….	☐	☐	Allergy- Latex..……………………	☐	☐
Barbiturates/Sedatives/Sleeping Pills…..……...	☐	☐	Codeine………………………………	☐	☐	Metal…...………………….………….	☐	☐
Antibiotics (Pennicillin, Amoxicillin etc.)………….	☐	☐	Acrylic…....…………………..……...	☐	☐	Other Allergies:___________________		

Are you taking any of the following:

	Yes	No		Yes	No		Yes	No
Antibiotics……………………...…………………	☐	☐	Allergy / Cold Remedies…..……	☐	☐	Digitalis/ Heart Meds………………	☐	☐
Blood Thinners ………………..…..……………	☐	☐	Birth Control Pills..………………	☐	☐	Nitroglycerin………………………	☐	☐
Blood Pressure Medication……..……….………	☐	☐	Tranquillizers……….……………	☐	☐	Aspirin……………………………	☐	☐
Thyroid Medication………………………………	☐	☐	Insulin / Diabetic Drugs…………	☐	☐	Osteoporosis Medication………....	☐	☐
Cortisone / Steroids………………..……………..	☐	☐	Recreational Drugs………………	☐	☐	Other Medications…………..……..	☐	☐

List any and all medications you are currently taking:……………………………………………………………………………………

………

Indicate which of the following you have had or have at the present:

	Yes	No		Yes	No		Yes	No
Heart Failure……………...………………………..	☐	☐	Stroke…………..……………………	☐	☐	Radiation Therapy………………	☐	☐
Heart Disease or Heart Attack……………....……	☐	☐	Artificial Joints (Hip/ Knee)…………	☐	☐	Chemo Therapy…………………	☐	☐
Angina Pectoris ……………………….…..……	☐	☐	Kidney Trouble………………………	☐	☐	Hepatitis A (Infectious)…………	☐	☐
Congenital Heart Disease………...…………	☐	☐	Ulcers…………………………………	☐	☐	Hepatitis B (Serum)……………	☐	☐
Heart Murmur…………………….….…………	☐	☐	Diabetes……………………………	☐	☐	Hepatitis C………………………	☐	☐
High Blood Pressure…………..………………	☐	☐	Thyroid Problems……………………	☐	☐	Venereal Disease………………	☐	☐
Arteriosclerosis………………………..…………	☐	☐	Glaucoma……………………………	☐	☐	A.I.D.S……………………………	☐	☐
Mitral Valve Prolapse……………...……………	☐	☐	Cosmetic Surgery……………………	☐	☐	H.I.V. Positive…………………..	☐	☐
Heart Pacemaker………………………..………	☐	☐	Emphysema…………………………	☐	☐	Blood Transfusion……………..	☐	☐
Rheumatic Fever……………..………………	☐	☐	Chronic Cough………………………	☐	☐	Hemophilia……………………...	☐	☐
Arthritis……………………………….…………	☐	☐	Tuberculosis…………………………	☐	☐	Anemia…………………………	☐	☐
Rheumatism……………………...……………	☐	☐	Asthma………………………………	☐	☐	Sickle Cell Disease……………..	☐	☐
Pain in Jaw Joints…………………...………	☐	☐	Hay Fever……………………………	☐	☐	Fainting or Bruise Easily………	☐	☐
Cortisone Medicine………………….…………	☐	☐	Allergies or Hives……………………	☐	☐	Liver Disease…………………..	☐	☐
Drug Addiction……………………………………	☐	☐	Sinus Trouble………………………	☐	☐	Bruise Easily……………………	☐	☐
Psychiatric Treatment……………..………	☐	☐	Nervousness…………………………	☐	☐	Jaundice………………………..	☐	☐
						Epilepsy or Seizures…………..	☐	☐

Is there any disease, condition or problem not listed above that you think we should know about,

or is there any activity your doctor days you cannot do? If so explain:…………………………………………………………………………

………

Dental History

Date of last dental visit and reason:

____

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

____

Do you have or have you ever had any of the following?

MOUTH	Yes	No
Bleeding or Sore Gums………….....	□	□
Unpleasant Taste/ bad breath….....	□	□
Burning Tongue / Lips…….…………	□	□
Frequent blisters, Lips / Mouth……..	□	□
Swelling / Lumps in Mouth…………	□	□
Ortho Treatment…..………..………	□	□
Biting Cheek……………………...….	□	□
Clicking / Popping………………….	□	□
Difficulty Opening / Closing………..	□	□

TEETH	Yes	No
Loose Teeth…..…………….………	□	□
Sensitive to Hot/Cold………………	□	□
Sensitive to Sweets……………..…..	□	□
Sensitive to Biting……………………	□	□
Food Impaction………..………………	□	□
Clenching / Grinding………………	□	□
Shifting of Teeth……….……………	□	□
Change in Bite……..………………..	□	□

ORAL HYGIENE	Yes	No
Do you use the following?		
Brush………...………………………	□	□
Dental Floss.…...…...…………………	□	□
Fluoride Rinse..…………………..	□	□
Other…..…...…………………………	□	□

How often do you brush?...............................

Brush is Soft, Medium, Hard?.........................

How often do you floss?...................................

Are you happy with the look of your teeth?.............Yes □ No □ Why?...

CONSENT:

Your signature attests that the above information is correct to the best of my knowledge and authorizes Dr. Toaldo to take x-rays, study models, photographs and or any other diagnosis of the patient's needs. It is important to know that the use of anesthetic agents may embody a certain risk. I understand that the responsibility for payment for Dental Services provided in this office for myself or dependent is mine, due and payable at time when services are rendered. In the event of default, you are responsible for the interest and indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient / Parent Signature________________________________Date_____________

Reviewed by:____Date______________

Please add any additional information you feel important to your dental treatment: