

WELCOME

ALDO LEOPARDI

PATIENT INFORMATION

Date _____
 Patient _____
 Address _____
 City _____
 State _____ Zip _____
 E-mail _____
 Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
 Occupation _____
 Patient Employer/School _____
 Employer/School Address _____
 Employer/School Phone (____) _____
 Spouse's Name _____
 Birthdate _____
 SS# _____
 Spouse's Employer _____
 Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____

ASSIGNMENT AND RELEASE

Signature of Patient, Parent, Guardian or Personal Representative)

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext. _____ Cell Phone (____) _____
 Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
 Home Phone (____) _____ Work Phone (____) _____

DENTAL HISTORY

Reason for today's visit _____	Chew on one side of mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mouth breathing	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	Cigarette, pipe, or cigar smoking	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mouth pain, brushing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Former Dentist _____	Clicking or popping jaw	Yes <input type="checkbox"/> No <input type="checkbox"/>	Orthodontic treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>
City/State _____	Dry mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pain around ear	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of last dental visit _____	Fingernail biting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Periodontal treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of last dental X-rays _____	Food collection between the teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sensitivity to cold	Yes <input type="checkbox"/> No <input type="checkbox"/>
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Foreign objects	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sensitivity to heat	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bad breath	Grinding teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sensitivity to sweets	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding gums	Gums swollen or tender	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sensitivity when biting	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blisters on lips or mouth	Jaw pain or tiredness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sores or growths in your mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Lip or cheek biting	Yes <input type="checkbox"/> No <input type="checkbox"/>	How often do you floss? _____	
	Loose teeth or broken fillings	Yes <input type="checkbox"/> No <input type="checkbox"/>	How often do you brush? _____	

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names for phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>	Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Respiratory Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis, Rheumatism	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting or dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Scarlet Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Heart Valves	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Shortness of Breath	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Joints	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin Rash	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Special Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding abnormally, with extractions or surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis Type _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen Feet or Ankles	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen Neck Glands	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemical Dependency	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaw Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tonsillitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Circulatory Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Lesions	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tumor or growth on head or neck	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cortisone Treatments	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cough, persistent or bloody	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervous Problem	Yes <input type="checkbox"/> No <input type="checkbox"/>	Weight Loss, unexplained	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you wear contact lenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Psychiatric Care	Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Radiation Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Women:

Are you pregnant? Yes No Due date _____ Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ALLERGIES

- Aspirin
- Barbiturates (Sleeping pills)
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other