PATIENT INFORMATION

Date_____

Patients name_____ Home phone_____
Last First Middle

Home address_____ City_____ Zip_____

Birth date_____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Nearest relative_____ Phone_____

Whom may we contact in case of an emergency _____

Phone _____

Whom may we thank for your referral _____

PERSON RESPONSIBLE FOR THIS ACCOUNT:

Name_____ Name of spouse _____

Mailing address _____

Responsible Party's employer _____ Spouse's employer_____

Birth date _____ Birth date _____

Work phone _____ Work phone _____

Social Security # _____ Social Security # _____

Occupation _____ Occupation _____

Yrs. with firm _____ Yrs. with firm_____

DENTAL INSURANCE COVERAGE ☐ **YES** ☐ **NO**

If so, please complete the following:

_____ _____
Name of Carrier - Ins. Co. Name Name of Carrier - Ins. Co. Name

_____ _____
Address Address

_____ _____
Group # Plan # Social Security # Group # Plan # Social Security #

_____ _____
Name of employee who has the coverage Name of employee who has coverage

_____ _____

_____ _____

_____

APPOINTMENTS: A broken appointment is a loss to everyone. Please inform us two days in advance if you are unable to keep your appointment.

PERMISSION FOR TREATMENT: I hereby grant permission for William L. Ciao, D.M.D., and staff to perform necessary diagnostic services, anesthesia or sedation, emergent and pertinent Dental Treatment.

I understand that the risk of complications accompany all dental procedure; that certain existing conditions may compromise the results, and that a perfect result cannot be guaranteed.

Date_____ Signature_____

PATIENT INFORMATION

MEDICAL HISTORY

* The last time we reviewed your medical history was _____. Since then have there been any changes?

Regular Physician_____

1. Do you have any allergies to drugs or medications? _____

   Medications? _____

   Metals?_____ Latex? _____

* 2. Have you ever had any surgeries?

* 3. Have you ever been hospitalized?

* 4. Do you have any medical problems?

* 5. Are you under current medical treatment?

   For what?

* 6. What medications do you currently take?

7. Do you have any artificial joints or heart valves?

8. Have you ever had Rheumatic Fever or a heart murmur?

* 9. Do you have any infectious diseases?

*10. Are you pregnant?

11. Have you had any problems with dental treatment?

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