Christopher J. Falvello, DDS, General & Implant Dentistry/Welcome

Today's Date: _____ How were you referred to our office? _____

Patient's Name: _____ If Minor, Parents/Guardian: _____

Birthdate: _____ Social Security #: _____ Sex: M F E-Mail Address:_____

Home Address: _____City _____ State _____ Zip_____

Telephone (Home): _____ (Work):_____ (Cell):_____

Medical History

Physician's Name(s): _____

List **ALL** prescription or over the counter medicines you are currently taking: _____

_____

List any serious medical condition(s) that you have had in past 5 years: _____

Have you ever had any of the following diseases or medical problems? Please circle

Y N Rhuematic Fever	Y N Artificial Bones/Joints	Y N Osteoporosis/Fosamax/Boniva/Actonel
Y N Heart Disease	Y N Artificial Valves	Y N HIV+/AIDS
Y N Heart Attack/Stroke	Y N Heart Surgery/Pacemaker	Y N Epilepsy/Seizures/Fainting
Y N Cancer/Chemotherapy	Y N Hepatitis	Y N Taking Bloodthinners
Y N Psychiatric Treatment	Y N Tuberculosis	Y N Seasonal Allergies
Y N Anemia/Blood Tranfusions	Y N Hemophilia/Abnormal Bleeding	Y N Severe/Frequent Headaches
Y N Glaucoma/Cataracts	Y N Asthma/Lung Problems	Y N Sinus Problems
Y N Diabetes	Y N Heart Murmur	Y N Recreational Drugs
Y N Currently Pregnant/Nursing	Y N Mitral Valve Prolapse	Y N Substance abuse/addiction
Y N Congenital Heart Defect	Y N Other (Please list) _____	

Are you allergic to any of the following? Please circle

Y N Penicillin	Y N Erythromycin	Y N Tetracycline	Y N Aspirin
Y N Codeine	Y N Dental Anesthetic	Y N Latex	Y N Other_____

Do you smoke? Y N If yes, how much per day?_____ How long have you been a smoker? _____

Date of last dental visit: _____ Treatment received: _____

Are you currently experiencing dental discomfort? _____ If yes, where? _____

Why have you come to the dentist today? _____

Methods of Payment (circle) CASH CHECK CREDIT CARD WELLS FARGO FINANCING

Name of Dental Insurance Carrier _____

Subscribers Name:_____ Group # _____ ID#_____

Subscriber's Birthdate:_____ Subscriber's Social Security # _____

Employer: _____ Address:_____

Employer Telephone: _____ Secondary Insurance? YES NO

*I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment, this includes radiographs (x-ray films). I give consent for Dr. Falvello to take photos or other images of my teeth for use in an educational setting and that my identity will not be revealed.

*I understand that I AM RESPONSIBLE for charges incurred by me, regardless of Insurance. I understand that Insurance payment is not always payment in full and I AM RESPONSIBLE for any Deductibles, Co-payments or Non-covered services and I will resolve any outstanding balance in a timely manner**. X**_____ DATE _____