Patient Information Form Date _____

Name _____Preferred Name _____ Birth Date_____
First M.I. Last

Address _____City _____ State _____ Zip _____

Cell # _____Home Phone _____ Soc Security _____

E-mail _____ Male Female

Please Circle: Minor Single Married Divorced Widowed Separated

Patient or parent's employer _____ Work Phone_____

Business Address _____ City _____ State _____ Zip _____

Spouse or parent's name ____ _____Employer _____Wk Phone_____

Whom may we thank for referring you? _____

Person to contact in emergency _____Phone _____

Previous Dentist _____(___)_____Last Exam _____ X-rays _____

Responsible Party

Name of person responsible for account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____Birth Date _____ Soc Security # _____

Employer _____ Work Phone _____

Insurance Information

Name of insured _____ Relationship to Patient _____

Birth Date _____ Soc Security # _____ Name of employer _____

Insurance Co. _____ Phone # _____Grp. # _____ ID # _____

Do you have any additional insurance? Yes No If yes, complete the following:

Name of insured _____ Relationship to Patient _____

Birth Date _____ Soc Security # _____ Name of employer _____

Insurance Co. _____ Phone # _____Grp. # _____ ID # _____

Authorization: I authorize the staff of Sciascia Dental to perform any necessary services needed during diagnosis and treatment. I authorize the provider to release any information required to process insurance claims.
Agreement: I understand the information given to me and guarantee this form and the medical and dental information were completed to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes to the information I have provided.

X_____ Date _____
Signature of patient (or parent, if minor)

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Nerve pills Pain Pills (including aspirin) Muscle Relaxers Stimulants Blood Thinners Tranzuilizers Insulin

Meds for Osteoporosis Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) yes no Phen-fen/Redux yes no

Yes No Are you taking any **other medication(s)?** _____
Yes No Are you allergic to any medication(s)? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have you seen a physician in the last 12 months? Why? _____

Female Patients Only:

Yes No Are you pregnant? If yes due date _____ Do you use birth control meds? Yes No

Are you allergic to any of the following? (please circle) Latex Penicillin/Amoxicillin Tetracycline Aspirin Dental Anesthetics Foods: _____ Others: _____

Circle any of the following medical conditions below that you have had or currently have.

Abnormal Bleeding/Hemophilia	Asthma or Hayfever	Epilepsy/Fainting/Seizures	Jaw Problems TMJ/TMD	Frequent Headaches
ADD/ADHD	Bleeding Problems	Heart Attack/Stroke	Kidney Problems	Sinus Problems
Alcohol/Drug Abuse	Cancer/Tumors	Heart Murmur	Leukemia	Tuberculosis
Anemia	Chemotherapy	Heart Surgery/Pacemaker	Mitral Valve Prolapse	Venereal Disease
Artificial Valves	Chest Pains	Hepatitis/Liver Problems	Nervousness or Disorders	X-Ray or Colbalt
Artificial Bones/Joints	Congenital Heart Defect	High/Low Blood Pressure	Respiratory Problems	Treatment
Arthritis/Rheumatism	Diabetes/Hypoglycemia	HIV+/Aids/ARC	Rheumatic Fever	

Do you require pre-medication for dental visits? Yes No Don't Know

DENTAL HISTORY

Reason for your visit _____Date of last visit _____
What concerns you most about your teeth? _____
Yes No Are you presently in any dental pain? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have there been any injuries to you face, mouth or teeth? _____
Yes No Do you like the appearance of your smile? If no, why? _____
Yes No Do your gums bleed? If yes, when? _____
Yes No Do you brush and floss regularly? Yes No Are you a mouth breather?
Yes No Are you aware of your jaw popping or clicking? Yes No Have your wisdom teeth been removed?
Yes No Are you aware of clenching your teeth during the day?

X_____ Date _____

Signature of patient (or parent, if minor)