

Welcome To Our Office

Today's date _____

Patient's Name _____

Home Address _____

City _____ State _____ Zip Code _____

E-mail Address _____

SS# _____ Date of Birth _____

Phone #'s: Home _____ Work _____ Cell _____

Occupation _____ Employer _____

Work Address _____

City _____ State _____ Zip Code _____

Guardian's Name (if applicable) _____

Relationship to the Patient _____ Phone # _____

Dentist's Name _____ Phone # _____

Are you currently under the care of a physician? Yes _____ No _____

Physician's Name _____ Phone # _____

If yes, why? _____

Please list any medications you are currently taking _____

Emergency Contact Name _____

Relationship to the Patient _____ Phone # _____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Do you have or have you ever had any of the following? (Type Yes or No)

- Heart Attack / Stroke / Chest Pain
- Heart Surgery / Heart Defect
- Rheumatic Fever
- Mitral Valve Prolapse
- Heart Murmur
- Prosthetic Heart Valve
- Prosthetic Joints (Knee, Hip, Shoulder, Etc.)
- High Blood Pressure
- Kidney Problems / Dialysis
- Thyroid Problems
- Hepatitis
- Ulcers / Gastrointestinal Problems
- Tuberculosis / Lung Disease / Pneumonia
- Diabetes
- Epilepsy / Seizures
- Enlarged Lymph Nodes
- Cancer
- Mental Health Problems / Anxiety / Depression

- Alcohol and/or Drug Abuse
- Glaucoma
- Immunosuppressive Drugs
- Radiation Treatment
- Chemotherapy
- Steroid Therapy
- Breathing Problems / Asthma
- Blood Transfusion
- Osteoporosis / Arthritis
- Bleeding Problems / Hemophilia
- Aspirin Therapy
- Sexually Transmitted Disease
- TMJ / Jaw Problem

Are You Currently:

- Taking Birth Control Pill
- Pregnant
- Nursing

Are you allergic to any of the following? (Type Yes or No)

- Latex
- Penicillin / Amoxicillin
- Sulfa
- Other Antibiotic _____

- Codeine or Other Narcotics
- Dental Anesthesia
- Other Allergy _____

Tell us about your tooth (Type Yes or No)

- Are you currently in Pain?
How long? _____
- Does the tooth hurt to Hot?
- Does the tooth hurt to Cold?
- Does the tooth hurt to Bite On?

- Has the area ever been Swollen?
If yes, when? _____
- Are you taking Antibiotics?
If yes, which one? _____
- Are you taking Pain Medication?
If yes, which one? _____

Is there anything else about your Medical or Dental history the doctor should know? Yes _____ No _____
If yes, what? _____

ACKNOWLEDGMENT OF CANCELLATION AND NO SHOW POLICY

We require 24 hours notice of any cancellation. Depending upon the circumstances, failure to cancel same day or not show up for your appointment may incur a \$150.00 cancellation fee. (_____ <--Initial Here)

FINANCIAL INFORMATION

Please be aware, this office only accepts assignment of benefits from certain insurance companies. You may have a co-insurance or you may be responsible for the entire fee. Please discuss your insurance or financial concerns prior to beginning treatment. Payment in full is expected for professional services rendered. (_____ <--Initial Here)

To the best of my knowledge the information given above is accurate and I agree to inform this office of any changes.

I authorize Dr. Anthony Fasciano and any agents, employees, or assistants to perform the procedures necessary for my dental treatment.

Signature _____ Date _____