NEW PATIENT MEDICAL HISTORY FORM

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NAME _____ DATE _____

PREFERRED NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE # HOME ( ) _____ WORK ( ) _____ EXT

CELL # ( ) _____ EMAIL _____

DATE OF BIRTH _____ SEX (CIRCLE) M F

OCCUPATION _____

EMPLOYER _____

SOCIAL SECURITY # _____ - _____ - _____

NAME OF SPOUSE/CLOSEST RELATIVE _____

PHONE ( ) _____

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP TO THIS PERSON? _____

HOW DID YOU HEAR ABOUT US? _____

DENTAL HISTORY:

FREQUENCY OF VISITS TO DENTIST _____

TYPE OF CARE RECEIVED _____

DIFFICULTIES WITH PAST TREATMENT _____

ADVERSE REACTIONS TO LOCAL ANESTHETICS, LATEX GLOVES, RUBBER DAM _____

DATE OF MOST RECENT DENTAL X-RAYS _____

DO YOU LIKE THE APPEARANCE OF YOUR SMILE? _____

DO YOU LIKE THE COLOR OF YOUR TEETH? _____

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MEDICAL HISTORY

PHYSICIAN NAME _____ PHONE ( ) _____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS: (CHECK ONE)

- ☐ BONE DEFORMITY, FRACTURE
- ☐ PROSTHETIC JOINT REPLACEMENT
- ☐ EARACHE
- ☐ FREQUENT SORE THROAT
- ☐ HOARSENESS
- ☐ RESPIRATORY PROBLEMS, BRONCHITIS, EMPHYSEMA, ETC.
- ☐ ASTHMA
- ☐ TUBERCULOSIS
- ☐ SHORTNESS OF BREATH
- ☐ PAIN, PRESSURE IN CHEST
- ☐ SWELLING OF ANKLES
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ RHEUMATIC FEVER/SCARLET FEVER
- ☐ HEART MURMUR, HEART ATTACK, MITRAL VALVE PROLAPSE
- ☐ VALVE REPLACEMENTS-PACEMAKERS
- ☐ ARE YOU A TOBACCO USER?
- ☐ ARE YOU TAKING ANY MEDICATIONS, INCLUDING NON-PRESCRIPTION MEDICINE? (ASPIRIN, BABY ASPR IN, CORTICOSTEROIDS, HERBAL SUPPLEMENTS, ETC.) IF SO, WHAT?

  _____

- ☐ CONGENITAL HEART LESIONS
- ☐ DIFFICULTIES SWALLOWING
- ☐ HEPATITIS, JAUNDICE, LIVER DISEASE
- ☐ DIABETES
- ☐ EXCESSIVE THIRST
- ☐ THYROID PROBLEMS
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ ANEMIA
- ☐ HIV INFECTION, AIDS
- ☐ LEUKEMIA, PROBLEMS WITH IMMUNE SYSTEM
- ☐ SPLEEN PROBLEMS
- ☐ FREQUENT HEADACHES
- ☐ DIZZINESS, FAINTING, SEIZURES
- ☐ EPILEPSY OR OTHER NEUROLOGICAL DISEASE
- ☐ RADIOTHERAPY/CHEMOTHERAPY
- ☐ OTHER _____
- ☐ HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS, OR BEEN HOSPITALIZED WITHIN THE LAST FIVE YEARS? IF SO, WHAT WAS THE ILLNESS OR PROBLEM?

  _____

- ☐ DO YOU HAVE ANY KNOWN ALLERGIES OR ADVERSE REACTIONS TO ANY MEDIATIONS?

  _____

DENTAL INSURANCE DATA:

PLAN NAME: _____

SUBSCRIBER'S NAME _____ RELATION _____

GROUP # _____ I.D. # _____

INSURANCE CO-PAYMENTS ARE EXPECTED ON THE DAY OF SERVICE.
A DISCOUNT IS OFFERED TO PATIENTS WITHOUT INSURANCE WHO PAY THEIR BALANCE IN FULL ON THE DAY OF SERVICE.
FOR CANCELLATIONS WITHOUT 24 HOURS NOTICE, A FEE WILL BE CHARGED.

DIGITAL IMAGES TAKEN OF YOU OR YOUR SMILE MAY BE USED TO EDUCATE OTHER PATIENTS/HEALTH PROVIDERS. ☐ I DO ☐ DO NOT GIVE DOCTOR GIANGRASSO'S OFFICE PERMISSION TO SHOW MY IMAGES TO OTHER PATIENTS/ HEALTH PROVIDERS

SIGNATURE _____ DATE _____

UPDATED SIGNATURE _____ DATE _____