

Welcome To Our Office

Name of Patient _____

I prefer to be called _____ Male ___ Female ___

Is patient a full-time student? Yes ___ No ___ Name of college _____

If the patient is a child, do you have legal custody? Yes ___ No ___

Your name _____ Relationship _____

Birthdate _____ Age ___ Social Security # _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____

Cell Phone _____ E-mail address _____

Single ___ Married ___ Divorced ___ Widowed ___ Separated ___ Spouse's Name _____

In case of emergency contact: _____ Phone # _____ Relationship _____

Whom may we thank for referring you to our office? _____

Previous Dentist _____ City _____

PRIMARY INSURANCE

Insured's name _____

Insured's SS # _____

Insured's birthdate _____

Insured's employer _____

Insurance Company _____

Group # _____

Insurance phone _____

SECONDARY INSURANCE

Insured's name _____

Insured's SS # _____

Insured's birthdate _____

Insured's employer _____

Insurance company _____

Group # _____

Insurance phone _____

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.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for payment of services rendered. I am responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize the dental insurance payment to be paid directly to Dr Valo. I understand that I am responsible for all costs of dental treatment and any amount not paid by insurance within 90 days. I hereby authorize release of any information, including the diagnosis, treatment, or examination rendered to my insurance company.

Signature _____ Date _____

Medical History

Name _____

Date _____

Your current health is: Good Fair Poor

Physician's Name and Phone # :

Location/City: _____ Date last visit: _____

Are you currently under the care of a physician?

Yes No

If so, please explain: _____

Local emergency contact: _____

Phone # _____

Relationship _____

Do you smoke or use tobacco in any form? Y N

Do you have any metal rods, pins, or implants? Y N

Are you taking any prescription or over-the-counter medications, vitamins/supplements? Y N

Please list:

Have you ever taken bisphosphonate medications (such as Fosamax, Actonel, Boniva, Zometa, Reclast, or Aredia)? Y N

For Women: Are you taking birth control pills? Y N

Are you pregnant? Y N Week # _____

Are you nursing? Y N

Are you allergic to any of the following?

Y N Aspirin

Y N Codeine

Y N Penicillin

Y N Fresh Fruits and Vegetables

Y N Tetracycline

Y N Erythromycin

Y N Dental Anesthetics

Y N Latex

Y N Sulfites

Y N Sulfa

Please list any other drugs you are allergic to:

Has your doctor recommended antibiotic premedication for any of the following?

Heart conditions, Rheumatic/Scarlet Fever,

Implants, Artificial Joints?

Y N

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

Y N Abnormal bleeding

Y N Alcohol/Drug Abuse

Y N Anemia

Y N Arthritis

Y N Artificial Bones/Joints/Valves

Y N Asthma

Y N Bacterial Endocarditis

Y N Blood Transfusion

Y N Cancer/Chemotherapy

Y N Colitis

Y N Congenital Heart Defect

Y N Diabetes

Y N Difficulty Breathing

Y N Emphysema

Y N Epilepsy

Y N Fainting Spells

Y N Frequent Headaches

Y N Glaucoma

Y N Hay Fever

Y N Heart Attack

Y N Heart Surgery

Y N Hemophilia

Y N Hepatitis

Y N Herpes/Fever Blisters

Y N High Blood Pressure

Y N HIV+/AIDS

Y N Kidney Problems

Y N Liver Disease

Y N Low Blood Pressure

Y N Osteoporosis/Osteopenia

Y N Pacemaker

Y N Psychiatric Problems

Y N Radiation Treatment

Y N Rheumatic/Scarlet Fever

Y N Seizures

Y N Shingles

Y N Sickle Cell Disease/Traits

Y N Sinus Problems

Y N Sjogren's Syndrome

Y N Stroke

Y N Systemic Pulmonary Shunt

Y N Thyroid Problems

Y N Tuberculosis (TB)

Y N Ulcers

Y N Veneral Disease

Reviewed by : _____ Date : _____