WELCOME

DATE _____

SOCIAL SECURITY # _____

HOME PHONE _____

CELL PHONE _____

PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

NAME _____ BIRTHDATE _____ E-MAIL _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

SEX: ☐ MALE ☐ FEMALE

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ **YES** ☐ **NO**

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYFD _____

EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE?_____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ **YES** ☐ **NO** **IF YES, COMPLETE THE FOLLOWING:**

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYFD _____

EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE?_____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

PATIENT MEDICAL HISTORY

PHYSICIAN_____ OFFICE PHONE_____ DATE OF LAST EXAM_____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NONPRESCRIPTION MEDICINE?	☐	☐
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL. COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

IF **YES**. WHAT MEDICATION(S) ARE YOU TAKING?_____

_____

7. ARE YOU ALLERGIC TO OR HAVE YOU: HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	LOCAL ANESTHETICS (AG. NOVOCAINE	☐	☐	BARBITURATES	☐	☐	ASPIRIN
☐	☐	PENICILLIN	☐	☐	SEDATIVES	☐	☐	OTHER
☐	☐	OTHER ANTIBIOTICS			_____			_____
☐	☐	SULFA DRUGS	☐	☐	IODINE			_____

8. WOMEN ONLY:

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

9. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	THYROID PROBLEM	☐	☐	HEPATITIS / JAUNDICE	☐	☐	LIVER DISEASE
☐	☐	HEART ATTACK	☐	☐	HEART DISEASE	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	HEART TROUBLE
☐	☐	RHEUMATIC FEVER	☐	☐	CARDIAC PACEMAKER	☐	☐	STOMACH TROUBLES / ULCERS	☐	☐	RESPIRATORY PROBLEMS
☐	☐	SWOLLEN ANKLES	☐	☐	HEART MURMUR	☐	☐	CHEST PAINS	☐	☐	OTHER_____
☐	☐	FAINTING / SEIZURES	☐	☐	ANGINA	☐	☐	EASILY WINDED			_____
☐	☐	LOW BLOOD PRESSURE	☐	☐	FREQUENTLY TIRED	☐	☐	STROKE			_____
☐	☐	EPILEPSY / CONVULSIONS	☐	☐	ANEMIA	☐	☐	HAY FEVER / ALLERGIES			_____
☐	☐	LEUKEMIA	☐	☐	EMPHYSEMA	☐	☐	TUBERCULOSIS			_____
☐	☐	DIABETES	☐	☐	CANCER	☐	☐	RADIATION THERAPY			_____
☐	☐	KIDNEY DISEASES	☐	☐	ARTHRITIS	☐	☐	GLAUCOMA			INITIAL_____
☐	☐	AIDS OR HIV INFECTION	☐	☐	JOINT REPLACEMENT / IMPLANT	☐	☐	RECENT WEIGHT LOSS			DATE_____

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIOUIDS/FOODS?	☐	☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. HAVE VOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	☐	☐
B) PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C) DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D) DIFFICULTY IN CHEWING?	☐	☐
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVE HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

ASSIGNMENT and RELEASE

I hereby authorize payment directly to Dr. Filangeri for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and / or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X_____ _____

PATIENT, PARENT OR GUARDIAN DATE

FOR FUTURE USE ONLY

If there are NO changes since your last visit, please date and initial below.

Date & Initial:_____ Date & Initial:_____ Date & Initial:_____

Date & Initial:_____ Date & Initial:_____ Date & Initial:_____

Date & Initial:_____ Date & Initial:_____ Date & Initial:_____