Fabozzi Dental
family dentistry

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Last Name _____ First Name _____ MI ____ Date _____

SS/HIC/Patient ID# _____ Birth date _____ E-mail _____

Address _____ City _____ State _____ Zip _____

☐Female ☐Male | ☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced Partnered for____ years

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Do you prefer to receive calls at (check one) ☐Home ☐Work ☐Cell ☐No Preference

Patient Employer/School _____ Occupation _____

Employer/ School Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer Work Phone # _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone # _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security# _____ Date Employed _____

Name of employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group# _____ Employer# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

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

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security# _____ Date Employed _____

Name of employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group# _____ Employer# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

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Dental History

Name _____ Age _____ Date of last exam _____

Former Dentist _____ Date of last dental X-rays _____

Reason for today's visit _____

How often do you brush? _____ How often do you floss? _____

Please check any of the following conditions that apply to you:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

Medical History

Some health conditions are the result of hereditary weaknesses. Information that you can furnish us pertaining to your immediate family members (brothers, sisters, parents and grandparents) will give us a better understanding of your health needs.

Relationship to you	Family member present and past health problems

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____ Phone _____

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin/Antibiotics
- ☐ Sulfa
- ☐ Other _____

Check (✓) any symptom(s) or condition(s) below that you currently have or have had in the past year.

- ☐ AIDS
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain or Numbness
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Depression/Nervousness
- ☐ Epilepsy
- ☐ Fever
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Indigestion
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Sore That Won't Heal
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis

Have you had any other diseases or systemic conditions not mentioned above?

Please list: _____

Have you ever been hospitalized? If so, what for?

_____

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Medical History continued...

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check degree of habits below. All information will be kept strictly confidential.

	Heavy	Casual	Light	None		Heavy	Casual	Light	None		Heavy	Casual	Light	None
Alcohol	☐	☐	☐	☐	Soft Drinks	☐	☐	☐	☐	Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐	Sugar/Sugar Products	☐	☐	☐	☐	Water	☐	☐	☐	☐

Have you ever taken any of these medications? (check all that apply)

☐ Dexfenfluramine	☐ Fen-phen/Pondimin/Redux	☐ Actonel	☐ Fosamax
☐ Coumadin	☐ Warfarin	☐ Boniva	
☐ Levoxyl	☐ Synthroid	☐ Skelid	

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____
Name of Insurance Company(ies)

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use or my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Certification and Assignment

I have read the Dental Materials Fact Sheet regarding the structure or device intended to remain in mouth indefinitely.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date