

Patient Information

Patient Name: _____ Date: _____

Social Security#: _____ Birth Date: _____

Address: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Responsible Party Information

Name: _____
 () Male () Female () Married () Single () Parent () Other _____

Social Security #: _____ Birth Date: _____

Address: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____

Insurance Information

Primary Insurance Plan Name _____

Subscriber's Name _____ Birth Date: _____
 ID#: _____ Group#: _____

Secondary Insurance Plan Name _____

Subscriber's Name _____ Birth Date: _____
 ID#: _____ Group#: _____

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services at the time that they are rendered.

Preferred Method of Payment () Cash () Check () Credit Card

Signature of Patient or Responsible Party _____

Whom may we thank for referring you _____

HEALTH HISTORY
CIRCLE

PLEASE

- 1) Are you in good health?.....YES NO
 - 2) Has there been any change in your general health within the past year?.....YES NO
 - 3) My last physical examination was on _____
 - 4) Physician's name and address _____

 - 5) Are you now under the care of a physician?.....YES NO
 a) If so, what condition is being treated? _____
 - 6) Have you had any serious illness or operation?.....YES NO
 a) If so, what? _____
 - 7) Do you have or have you had any of the following:
- | | |
|--|----------------------------------|
| Tire easily, weakness.....YES NO | Rheumatic fever.....YES NO |
| Marked weight change.....YES NO | Heart Murmur.....YES NO |
| Night sweats.....YES NO | Chest pain/discomfort....YES NO |
| Persistent fever.....YES NO | Heart attack/trouble....YES NO |
| Eruptions (rash) hives.....YES NO | Shortness of breath.....YES NO |
| Change in skin color.....YES NO | Swelling of ankles.....YES NO |
| Visual change.....YES NO | High blood pressure.....YES NO |
| Glaucoma.....YES NO | Congenital heart disease..YES NO |
| Loss of hearing.....YES NO | Artificial heart valve...YES NO |
| Ringing of ears.....YES NO | Pacemaker.....YES NO |
| | Heart surgery.....YES NO |
| | Other.....YES NO |
| Frequent nose bleeds.....YES NO | Arthritis.....YES NO |
| Sinus trouble.....YES NO | Artificial joints.....YES NO |
| Persistent throat soreness/hoarseness...YES NO | Rheumatism.....YES NO |
| Stroke.....YES NO | Hepatitis.....YES NO |
| Frequent headaches.....YES NO | Jaundice.....YES NO |
| Convulsions/epilepsy.....YES NO | Kidney disease.....YES NO |
| Numbness/tingling.....YES NO | Liver disease.....YES NO |
| Dizziness/fainting.....YES NO | Ulcers.....YES NO |
| Psychiatric treatment.....YES NO | |
| | Bruise easily.....YES NO |
| Tuberculosis.....YES NO | Anemia.....YES NO |
| Emphysema.....YES NO | Other blood disorder....YES NO |
| Asthma/hay fever.....YES NO | Blood transfusion.....YES NO |
| Persistent cough.....YES NO | |
| Cough up blood.....YES NO | Radiation therapy.....YES NO |
| | HTLV virus (Aids virus)..YES NO |
| Diabetes.....YES NO | Tumor or growth.....YES NO |
| Thyroid condition.....YES NO | Cancer.....YES NO |

(over)

If patient is a child: Is child taking fluoride vitamins? Yes No

8) Are you ALLERGIC or have you reacted adversely to:

Local anesthetics (e.g. novocaine) Yes No	Aspirin Yes No
Penicillin Yes No	Codeine Yes No
Other antibiotics Yes No	Other narcotics Yes No
Sulfa Drugs Yes No	Barbiturates/Sedatives/Sleeping pills Yes No

* Other allergies including food, metals, adhesive tape, etc. _____

9) Are you taking any of the following DRUGS or MEDICATIONS?

Antibiotics Yes No	Tranquilizers Yes No
Blood Thinners Yes No	Insulin Yes No
Medications Yes No	Other Diabetic Drugs Yes No
Thyroid Meds. Yes No	Digitalis Yes No
Cortisone/Steroids Yes No	Nitroglycerin Yes No
Antihistamines/ Allergy Drugs Yes No	Other heart drugs Yes No
OTHER _____	Cold Remedies Yes No
	Aspirin Yes No

*If Yes to any of the above, list NAME and DOSAGE of medication.

10) Is there any disease, condition, or problem not listed above that you think we should know about, or is there an activity your doctor says you cannot do? If YES, explain.

11) Have you ever had any serious trouble associated with previous dental treatment?

12) If female, are you pregnant? Yes No

To the best of my knowledge, all the preceding answers are correct.

If I ever have any change in my health or medication, I will inform Dr. Riccobono/Dr. Cohn at my next appointment.

Signature of Patient, Parent, or Guardian _____ Date _____

Dr. Riccobono D.D.S.: _____ Date _____

Dr. Viki Cohn D.D.S.: _____ Date _____