PATIENT'S DENTAL HISTORY

When was your last dental visit? _____

What was done at that time? _____

Are you satisfied with the appearance of your teeth? _____

How often do you brush? _____ Floss? _____

Do you use dental floss? _____ Yes _____ No

Do you use a soft tooth brush? _____ Yes _____ No

Water Pik? _____ Yes _____ No

Do your gums bleed? _____ Yes _____ No

Do you have any pain or soreness in teeth/gums? _____ Yes _____ No

Are your teeth sensitive to sweets, temperature, or pressure? _____ Yes _____ No

Do you notice popping or clicking in your jaw? _____ Yes _____ No

Do you clench or grind your teeth? _____ Yes _____ No

Have you had any teeth removed? _____ Yes _____ No

Have you had Orthodontic Treatment (Braces)? _____ Yes _____ No

Have you had Periodontic Treatment? _____ Yes _____ No

List any dental condition of which you are aware that has not been mentioned: _____

_____

Do you have a dental problem which you believe requires immediate attention? _____

_____

Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

PATIENT'S INFORMATION FORM

Patient's Name: _____ Date of Birth: _____

Address: _____ Social Security No.: _____

City, State, Zip: _____ Home Phone: ( ) _____

E-Mail Address: _____ Cell Phone: ( ) _____

Sex: ❑ Female ❑ Male Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Patient's Name of Employer: _____ Work Phone: ( ) _____

Address: City, State & Zip: _____

EMERGENCY CONTACT INFORMATION - Who should we contact in case of an emergency:

Name: _____ Phone: ( ) _____ Relation to Patient: _____

GUARANTOR INFORMATION (Person responsible for the account):

Guarantor's Name: _____ Home Phone: ( ) _____

Address: _____ (if different from the patient)

City, State, Zip: _____ Cell Phone: ( ) _____

Guarantor's Date of Birth: _____ Social Security No.: _____

Guarantor's Name of Employer: _____ Work Phone: ( ) _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of Insurance: _____

Policy/Subscriber's Name: _____

Date of Birth: _____/_____/_____

Social Security #: _____-_____-_____

Relationship to Patient: _____

ID #: _____

Group #: _____

Secondary Insurance

Name of Insurance: _____

Policy/Subscriber's Name: _____

Date of Birth: _____/_____/_____

Social Security #: _____-_____-_____

Relationship to Patient: _____

ID #: _____

Group #: _____

AUTHORIZATION RELEASE

I hereby give Dr. Gambacorta & Dental Associates permission to diagnose, treat and care for all my dental needs. I further authorize Dr. Gambacorta & Dental Associate permission to release any information related to dental insurance claim processing for direct payment from my insurance carrier for services rendered.

I hereby authorize Dr. Gambacorta & Dental Associates permission to obtain a credit investigation report if credit is extended on behalf of any member of my family associated with this account.

I understand that in the event my account becomes delinquent and is assigned to a collection agency, I will be responsible for the current collection rate/fees (%) which will be added on to the principal amount. If my account is assigned to an attorney for litigation, I understand I will be responsible for any attorney fees and court costs.

Patient, Parent/Guardian Signature: _____ Date: _____

PATIENT HEALTH HISTORY

Patient's Name: _____ Date of Birth: _____

ANSWER ALL QUESTIONS BY CIRCLING YES (Y) or NO (N)

1. Are you in good health ..... Y N
2. Has there been any changes in your health over the past year? ..... Y N
3. Date of last physical exam: _____
4. Are you now under a physician's care ..... Y N
5. Have you ever had a serious illness ..... Y N

(PLEASE LIST ON REVERSE SIDE)

1. DO YOU HAVE OR HAVE YOU EVER HAD:

A. Rheumatic Fever or Rheumatic Heart Disease ..... Y N
B. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
C. Lung Disease (Asthmas, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing? ..... Y N
D. Seizures, Convulsion, Epilepsy, Fainting or dizziness? ..... Y N
E. Bleeding Disorder, Anemia, and Bleeding Tendency, Transfusion? Do you bruise easily? ..... Y N
F. Liver Disease? ..... Y N
G. Kidney Disease? ..... Y N
H. Diabetes? ..... Y N
I. Thyroid Disease (Goiter)? ..... Y N
J. Arthritis? ..... Y N
K. Stomach Ulcers or Colitis? ..... Y N
L. Glaucoma? ..... Y N
M. Osteoporosis? ..... Y N
N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
O. Radiation (X-ray) treatment for Cancer? ..... Y N
P. Clicking or Popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
Q. Sinus or Nasal problems? ..... Y N
R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N

2. ARE YOU USING ANY OF THE FOLLOWING?

A. Antibiotics? ..... Y N
B. Anticoagulants (blood thinners)? ..... Y N
C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ..... Y N
D. High Blood Pressure medications? ..... Y N
E. Steroids/Cortisone, Prednisone, etc.? ..... Y N
F. Tranquilizers? ..... Y N
G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
H. Digitalis, Nitroglycerin or other heart drugs? ..... Y N

ALL RESPONSES ARE CONFIDENTIAL

I. Are you taking ***or have you ever taken***: Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax Actonel, Boniva, Aredia, Zometa)? ..... Y N
J. Have you ever been advised not to take any medication? ..... Y N
K. Please list any and all medications taken including prescription medications, diet, drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

(PLEASE LIST ON REVERSE SIDE)

3. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

A. Local Anesthesia (Novocain, etc.)? ..... Y N
B. Penicillin or other antibiotics? ..... Y N
C. Sedatives, Barbiturates? ..... Y N
D. Aspirin or Ibuprofen? ..... Y N
E. Codeine or other pain killers ..... Y N
F. Latex or Rubber products ..... Y N
G. Metal of any kind? ..... Y N
H. Chemicals or jewelry (rash/sensitivity)? ..... Y N
I. Food products? ..... Y N
J. Other allergies or reactions? ..... Y N

(PLEASE LIST ON REVERSE SIDE)

1. Do you smoke or chew Tobacco? ..... Y N
2. How much per day? _____
3. Is here any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Y N
4. Have you had any serious problems associated with any previous dental treatment? ..... Y N
5. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
6. Do you wish to talk with the doctor privately about anything? ..... Y N

FOR WOMEN ONLY:

Are you Pregnant or is there any chance you might be Pregnant? ..... Y N
Are you nursing ..... Y N

IMPORTANT NOTICE

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult your Physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing me the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Signature of Person Completing Health History Date Doctor's Initial

Have you ever had any serious illnesses, surgery or hospitalizations? If so, describe:

Please list any and all medications taken including, prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or mineral:

Please list all allergies or reactions you have had to any medications:

Additional information (if you entered YES to any of the questions on page 1, please describe in detail below:

Physician's Name: _____

Physician's telephone No.: _____