Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name_____ Soc. Sec. #_____
Last Name *First Name* *Initial*

Address_____ City_____ State_____ Zip_____

Email_____ Home Phone_____ Cell Phone_____

Preferred method of contact for appointment reminders ☐ Home Phone ☐ Cell Phone (text) ☐ Email

Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Business Email_____ Whom may we thank for referring you?_____

Notify in case of emergency_____ Home Phone_____

Cell Phone _____ Business Phone_____ Email_____

Primary Insurance

Person Responsible for Account_____
Last Name *First Name* *Initial*

Relation to Patient_____ Birth date_____ Soc. Sec. #_____

Address (if different from patient)_____ Home Phone_____

City_____ State_____ Zip_____ Cell Phone_____

Email_____ Person Responsible Employed by_____

Occupation_____ Business Address_____

Business Phone_____ Business Email_____

Insurance Company_____ Phone_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan_____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient_____ Birth date_____

Address (if different from patient)_____ Soc. Sec. #_____

City_____ State_____ Zip_____ Home Phone_____

Cell Phone_____ Email_____

Subscriber employed by_____ Business Phone_____

Business Email_____

Insurance Company_____ Phone_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan_____

- Please complete other side -

Dental History

What would you like us to do today?_____Are you in dental discomfort today?_____

Former Dentist_____ Address_____

Dentist's Email_____Phone_____

Date of last dental care_____ Date of last x-rays_____
Check (✓) yes or no if you have had problems with any of the following:

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

How often do you brush?_____ Floss?_____

How do you feel about the appearance of your teeth?_____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Other information about your dental health or previous treatment_____

Medical History

Physician's name:_____ Phone_____ Date of last visit_____
Have you had any serious illnesses or operations? ☐ Y ☐ N

If yes, describe_____

Are you currently under physician care? ☐ Y ☐ N If yes, describe_____

Have you ever bad a blood transfusion? ☐ Y ☐ N If yes. give approximate dates_____
Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N
Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (✓) yes or no whether you have had any of the following:

☐ Y ☐ N AIDS/HIV Positive
☐ Y ☐ N Anaphylaxis
☐ Y ☐ N Anemia
☐ Y ☐ N Arthritis, Rheumatism
☐ Y ☐ N Artificial heart valves
☐ Y ☐ N Artificial joints
☐ Y ☐ N Asthma
☐ Y ☐ N Atopic (allergy prone)
☐ Y ☐ N Back problems
☐ Y ☐ N Blood disease
☐ Y ☐ N Cancer
☐ Y ☐ N Chemical dependency
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Venereal disease
☐ Y ☐ N Cough, persistent
☐ Y ☐ N Cough up blood
☐ Y ☐ N Diabetes
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting
☐ Y ☐ N Food allergies
☐ Y ☐ N Glaucoma
☐ Y ☐ N Headaches
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Heart problems
Describe_____
☐ Y ☐ N Hemophilia/
☐ Y ☐ N Herpes
☐ Y ☐ N Circulatory problems
☐ Y ☐ N Cortisone treatments
☐ Y ☐ N Jaw Pain
☐ Y ☐ N Kidney disease or malfunction
☐ Y ☐ N Liver disease
☐ Y ☐ N Material allergies (**latex**, wool, metal. chemicals)
☐ Y ☐ N Mitral valve prolapse
☐ Y ☐ N Nervous problems
☐ Y ☐ N Pacemaker/ Heart surgery
☐ Y ☐ N Psychiatric care
☐ Y ☐ N Rapid weight gain or loss
☐ Y ☐ N Respiratory disease
☐ Y ☐ N High blood pressure
☐ Y ☐ N Shingles
☐ Y ☐ N Shortness of breath
☐ Y ☐ N Skin rash
☐ Y ☐ N Spina Bifida
☐ Y ☐ N Stroke
☐ Y ☐ N Surgical implant
☐ Y ☐ N Swelling of feel or ankles
☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Tobacco habit
☐ Y ☐ N Tonsillitis
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Radiation treatment
☐ Y ☐ N Hepatitis
☐ Y ☐ N Rheumatic/Scarlet fever

Is patient currently taking any medications? If yes. list all:_____

Does patient have drug allergies? If yes. list all:_____

Financial Policy & Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Payment is due in full at time of treatment, unless other payment arrangements have been approved by Dr. Mancuso prior to the start of treatment. If the agreed upon payment is not received by the due date each month, it is the office policy to assign a late fee of $5.00, as well as interest of 1 1/2% per month (18% per annum). The patient also agrees that in the event they fail to pay their balance, they will be responsible for all costs of collections.

Signature_____ Date_____