WELCOME

ALDO LEOPARDI

PATIENT INFORMATION

Date _____
Patient _____
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex ❑ M ❑ F Age _____ Birthdate _____
❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered for _____ years
Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone (____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? ❑ Yes ❑ No
Subscriber's Name _____
Birthdate_____ SS#_____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

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

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

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext. _____ Cell Phone (_____) _____
Spouse's Work (_____) _____ Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
Name _____ Relationship _____
Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____
_____
Former Dentist _____
City/State_____
Date of last dental visit_____
Date of last dental X-rays _____
Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath Yes ❑ No ❑
Bleeding gums Yes ❑ No ❑
Blisters on lips or mouth Yes ❑ No ❑
Chew on one side of mouth Yes ❑ No ❑
Cigarette, pipe, or cigar smoking Yes ❑ No ❑
Clicking or popping jaw Yes ❑ No ❑
Dry mouth Yes ❑ No ❑
Fingernail biting Yes ❑ No ❑
Food collection between the teeth Yes ❑ No ❑
Foreign objects Yes ❑ No ❑
Grinding teeth Yes ❑ No ❑
Gums swollen or tender Yes ❑ No ❑
Jaw pain or tiredness Yes ❑ No ❑
Lip or cheek biting Yes ❑ No ❑
Loose teeth or broken fillings Yes ❑ No ❑
Mouth breathing Yes ❑ No ❑
Mouth pain, brushing Yes ❑ No ❑
Orthodontic treatment Yes ❑ No ❑
Pain around ear Yes ❑ No ❑
Periodontal treatment Yes ❑ No ❑
Sensitivity to cold Yes ❑ No ❑
Sensitivity to heat Yes ❑ No ❑
Sensitivity to sweets Yes ❑ No ❑
Sensitivity when biting Yes ❑ No ❑
Sores or growths in your mouth Yes ❑ No ❑

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

HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of lonimin, Adipex, Fastin (brand names for phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes ❑ No ❑

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes ❑ No ❑	Emphysema	Yes ❑ No ❑	Respiratory Disease	Yes ❑ No ❑
Anemia	Yes ❑ No ❑	Epilepsy	Yes ❑ No ❑	Rheumatic Fever	Yes ❑ No ❑
Arthritis, Rheumatism	Yes ❑ No ❑	Fainting or dizziness	Yes ❑ No ❑	Scarlet Fever	Yes ❑ No ❑
Artificial Heart Valves	Yes ❑ No ❑	Glaucoma	Yes ❑ No ❑	Shortness of Breath	Yes ❑ No ❑
Artificial Joints	Yes ❑ No ❑	Headaches	Yes ❑ No ❑	Sinus Trouble	Yes ❑ No ❑
Asthma	Yes ❑ No ❑	Heart Murmur	Yes ❑ No ❑	Skin Rash	Yes ❑ No ❑
Back Problems	Yes ❑ No ❑	Heart Problems	Yes ❑ No ❑	Special Diet	Yes ❑ No ❑
Bleeding abnormally, with extractions or surgery	Yes ❑ No ❑	Hepatitis Type_____	Yes ❑ No ❑	Stroke	Yes ❑ No ❑
		Herpes	Yes ❑ No ❑	Swollen Feet or Ankles	Yes ❑ No ❑
		High Blood Pressure	Yes ❑ No ❑	Swollen Neck Glands	Yes ❑ No ❑
Blood Disease	Yes ❑ No ❑	Jaundice	Yes ❑ No ❑	Thyroid Problems	Yes ❑ No ❑
Cancer	Yes ❑ No ❑	Jaw Pain	Yes ❑ No ❑	Tonsillitis	Yes ❑ No ❑
Chemical Dependency	Yes ❑ No ❑	Kidney Disease	Yes ❑ No ❑	Tuberculosis	Yes ❑ No ❑
Chemotherapy	Yes ❑ No ❑	Liver Disease	Yes ❑ No ❑	Tumor or growth on head or neck	Yes ❑ No ❑
Circulatory Problems	Yes ❑ No ❑	Low Blood Pressure	Yes ❑ No ❑		
Congenital Heart Lesions	Yes ❑ No ❑	Mitral Valve Prolapse	Yes ❑ No ❑	Ulcer	Yes ❑ No ❑
Cortisone Treatments	Yes ❑ No ❑	Nervous Problem	Yes ❑ No ❑	Venereal Disease	Yes ❑ No ❑
Cough, persistent or bloody	Yes ❑ No ❑	Pacemaker	Yes ❑ No ❑	Weight Loss, unexplained	Yes ❑ No ❑
Diabetes	Yes ❑ No ❑	Psychiatric Care	Yes ❑ No ❑		
Do you wear contact lenses?	Yes ❑ No ❑	Radiation Treatment	Yes ❑ No ❑		

Women:

Are you pregnant: Yes ❑ No ❑ Due date _____ Are you nursing? Yes ❑ No ❑

Taking birth control pills? Yes ❑ No ❑

MEDICATIONS

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

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

❑ Aspirin
❑ Barbiturates (Sleeping pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes ❑ No ❑

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes ❑ No ❑

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____