Welcome to Our Practice

Patient Information

NAME (LAST, FIRST, MIDDLE)_____Title _____

PREFERRED NAME _____ SOCIAL SECURITY #_____-_____-_____DATE OF BIRTH ___/___/_____

HOME ADDRESS _____

CITY_____ STATE_____ ZIP CODE_____ - _____

HOME PHONE _____MARITAL STATUS: S / M /D / W SEX: M / F

WORK PHONE_____ CELL PHONE_____EMAIL_____

EMPLOYER POSITION BUSINESS ADDRESS _____

NAME OF SPOUSE_____ SPOUSE SOCIAL SECURITY #_____-___-_____

NUMBER OF DEPENDANTS ____ NAMES AND AGES _____

NEAREST NEIGHBOR OR RELATIVE NOT LIVING WITH YOU? _____ PHONE_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Account Information

Person responsible for this account *(if different* than the above

NAME (LAST, FIRST, MIDDLE)_____ Title_____

RELATIONSHIP TO PATIENT_____ SOCIAL SECURITY #_____-___-_____DATE OF BIRTH___/___/_____

HOME ADDRESS:_____

CITY_____ STATE_____ ZIP CODE_____ -_____

HOME PHONE_____ MARITAL STATUS: S/M/D/W SEX: M/F

WORK PHONE _____

EMPLOYER_____ POSITION_____

BUSINESS ADDRESS _____

Out of Town Address

HOME ADDRESS _____

CITY_____ STATE/PROVINCE_____ ZIP CODE_____ -_____ COUNTRY _____

HOME PHONE: _____

It is understood that I, or we, will be responsible for all charges incurred on this account, to include all present and future services. I do understand that regardless of the insurance coverage that I might have, I am responsible for paying all charges. In the event of nonpayment of charges for services rendered, I agree to pay all costs of collection, including a reasonable attorney's fee. I have read this agreement and do understand its provisions. We may request/report credit information to CBU, a credit-rating institution.

Patient Signature_ _____

Name_____ Date_____

1. Are you in good health?..... YES NO

2. Have you had any serious illness or operation?..... YES NO
   If YES, please list:

3. Have you been under the care of a medical doctor during the past two years?..... YES NO
   Physician's Name
   Address Phone
4. Are you now taking any medication, drugs or pills? (including over the counter medications)..... YES NO
   If YES, please list:

5. Are you aware of being ALLERGIC to or have you ever reacted adversely to any medication or substance ..... YES NO
   If YES, please list:

6 Do you have or have you ever had:

Heart Failure /attack	YES	NO	Emphysema	YES	NO	Bleeding disorder	YES	NO
Heart Disease	YES	NO	Tuberculosis (TB)	YES	NO	Bruise easily	YES	NO
Angina Pectoris	YES	NO	Asthma	YES	NO	Anemia	YES	NO
High Blood Pressure	YES	NO	SinusTrouble	YES	NO	Blood Transfusion	YES	NO
Heart Murmur	YES	NO	Allergies	YES	NO	Stomach Ulcer or Colitis	YES	NO
Rheumatic Fever	YES	NO	Liver Disease	YES	NO	Syphilis, Gonorrhea, etc	YES	NO
Congenital Heart Disease	YES	NO	Hepatitis A (infectious))	YES	NO	Epilepsy or Seizures	YES	NO
Heart Palpitation	YES	NO	Hepatitis B (serum)	YES	NO	Fainting or Dizzy Spells	YES	NO
Artificial Heart Valve	YES	NO	Diabetes	YES	NO	Glaucoma	YES	NO
Heart Pacemaker	YES	NO	Thyroid Disease	YES	NO	Cortisone Medications	YES	NO
Heart Surgery	YES	NO	X-ray Treatment for Cancer	YES	NO	Difficulty opening mouth	YES	NO
Prolapsed Mitral valve	YES	NO	Chemotherapy (Cancer, Leukemia)	YES	NO	Clicking or popping of the jaw	YES	NO
Shortness of Breath	YES	NO	Arthritis/Rheumatism	YES	NO	Grind or clench teeth	YES	NO
Kidney Disease	YES	NO	Artificial Joints (hip, knee)	YES	NO	Pain near the ear	YES	NO
Stroke	YES	NO	Transplant Surgery	YES	NO	Recurring mouth sores	YES	NO

7. Any disease, drugs or transplant operation that has depressed your immune system?..... YES NO
   Recurrent infections of any kind?..... YES NO
8. Do you smoke or Chew tobacco?..... YES NO
   How much daily?
9. Do you use alcohol?..... YES NO
   How much?
10. Have you ever sought professional care for drug abuse, alcoholism or emotional disorders?..... YES NO
11. Do you take sleeping pills?..... YES NO
12. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..... YES NO
    IF YES please explain
13. Do you wish to talk with the doctor privately about anything?..... YES NO
14. **WOMEN:** Are you pregnant or planning pregnancy?..... YES NO
    Are you taking birth control pills?..... YES NO
    Do you wish to consult your physician to rule out pregnancy before beginning dental treatment?..... YES NO

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE.

_____ _____
SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DR'S INITIALS

DR. NOTES:

JOSEPH M. CAMUCCIO, D.D.S.

GETTING TO KNOW YOU

NAME_____

Date_____

Welcome to our practice – we're glad you've chosen to be our patient!

1. *Let's get acquainted. Tell us about you...*

Hobbies & interests _____

Family? Kids? (ages) _____

_____

Business / Occupation _____

Are you in the public eye? Is image important to you? _____

Would you like a complimentary Life-Time Dental Health plan? _____

2. *Today's dentistry allows us to enhance your smile quickly and easily. How would you like your smile to look?*

☐ Straighter	☐ Whiter	☐ Close spaces
☐ Longer	☐ Shorter	☐ More even
☐ Replace missing teeth	☐ Replace uncomfortable partials or dentures	
☐ Fresher Breath	☐ Other	

_____

3. *When would you like to begin?*

_____

4. *Are there any special occasions coming up? Weddings? Reunions? Photoshoot?*

_____

5. *What would you start with first?*

_____