BRIAN P. O'SULLIVAN D.M.D. • JAMES G. DeLUCA, D.M.D.

I. PATIENT INFORMATION RECORD

Name_____Age_____Status_____

Birthdate _____SS#_____Drivers License #_____

Address_____

City/State/Zip _____

Home Phone (_____)_____Work Phone (_____)_____

Cell Phone (_____)_____Email_____

Whom may we thank for referring you _____

II. EMPLOYMENT INFORMATION

Patient's Employer _____

Employer Address _____

City/State/Zip _____Phone (_____)_____

Spouse's Name _____DOB:_____

Spouse's Employer_____

Employer Address _____

City/State/Zip _____

Phone (_____) _____SS#_____

III. DENTAL INSURANCE INFORMATION

Insurance Name _____

Address_____

Phone #_____

Policy #_____

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, at the time of service, accounts over 90 days will be charged an interest fee of 1.5%/mo., 18%/yearly unless arrangements are made in advance.

I understand and agree that health insurance policies are an arrangement between INSURANCE CARRIER AND MYSELF. I understand and agree it is my responsibility to pay any deductible amount, co-insurance, or any other deductible amount, or any other balance not paid for by my insurance.

When charges are filed with your insurance carrier and assignment of insurance benefits is accepted by our office, if the fees are not paid within 60 days, all fees become the patient's responsibility. Our office charges a fee of $25.00 for any returned check and is subject to the terms below. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. A photocopy of this signature is as valid as the original. I also authorize the doctor to release all information necessary to secure payment.

Signed_____Date_____

MEDICAL DENTAL HISTORY FORM

Patient Name:
Patient ID #:

Medical Clinic _____

Physician _____

Allergies to:
Latex: Yes No
Medications _____
Other _____

PreMed required? Yes No

Reason: _____

Type: _____ Dosage: _____

Current Medications (Prescription, Over the counter and Herbal)

Please circle:

Do you presently take Coumadin, Warfarin, Plavix, Lovenox or Pradaxa?

Do you or have you ever taken Fosamax, Boniva, Zometra or Actonel?

	MEDICATION		FREQUENCY			MEDICATION		FREQUENCY	

PAST AND CURRENT MEDICAL CONDITIONS (mark all that apply)

	Yes	No
8. Under physician's care?		
Details:		
9. Hospitalization / operation(s) in last 5 years?		
Details:		
10. Head / neck / mouth injuries?		
11. Women: pregnant?		
12. Women: nursing?		
13. Women: oral contraceptives?		
14. Heart trouble / disease?		
15. Rheumatic fever?		
16. Past use of Fenphen?		
17. Heart murmur?		
18. Mitral valve prolapse?		
19. Heart surgery?		
20. Artificial heart valves?		
21. Pacemaker?		
22. Indwelling defibrillator?		
23. Artificial joints?		
24. History of Organ Transplant?		
25. High blood pressure? BP: /		
26. Stroke?		
27. Bleeding problem?		
28. Hemophilia?		
29. Anemia?		
30. Leukemia?		
31. Lung disease?		
32. Emphysema?		
33. Shortness of breath?		

	Yes	No
34. Asthma?		
35. Sleep Apnea?		
36. Tuberculosis?		
37. Sinus trouble?		
38. Cancer?		
39. Radiation Treatment to Head / Neck?		
40. Chemotherapy?		
41. Kidney Disease?		
42. Dialysis?		
43. Eating Disorder?		
44. Stomach: reflux? ulcer?		
45. Immunological disease?		
46. Sjogrens Disease?		
47. Fibromyalgia?		
48. Other autoimmune disease (lupus, pemphilus)?		
49. Arthritis or other joint disorders?		
50. Diabetes? Type: Controlled? Y N		
51. Headaches?		
52. Depression: Diagnosed?		
53. Other Psychiatric Disorders?		
54. Neurologic Disease?		
55. Convulsions?		
56. Epilepsy / seizures?		
57. Cerebral Palsy?		
58. Fainting / dizziness?		
59. Venereal disease?		
60. AIDS / HIV positive?		
61. Alcohol or chemical dependency?		
62. Hepatitis?		
63. Thyroid disease?		
64. Glaucoma?		

TOBACCO

	Yes	No
65. Tobacco user?		
Type:		
Amount:		
Number of years:		
66. How soon after wake up do you use tobacco? <30 minutes >30 minutes		
67. Previous attempts to quit?		
Number of attempts:		
Longer period of success:		
Methods used:		
68. Are you interested in quitting tobacco?		
69. Former tobacco user?		
Type:		
Amount:		
Year quit:		

DENTAL INFORMATION:

70. Previous dentist:
71. Last dental visit:
72. Last dental cleaning:
73. Frequency of dental exams:
74. What made you decide to make this dentist appointment?
75. Frequency of brushing:
76. Frequency of flossing:
77. What are some typical foods you eat between meals?
78. What types of beverages do you typically drink between meals?
79. How often do you chew or suck on hard candy, cough drops or mints?

	Yes	No
80. Do you use fluoridated toothpaste?		

81. Primary source of drinking water? (circle)
City water filtered City water unfiltered
Bottled water Well water

PAST DENTAL TREATMENT

	Yes	No
82. One or more fillings in the last three years?		
83. Family history of extensive decay?		
84. If child, mother's history of decay?		
85. Treatment for periodontal (gum) disease?		
86. Family history of periodontal disease?		
87. Have you had orthodontics (braces)?		
88. Have you had oral surgery?		
89. Have you had any dental implants placed?		
90. Treatment for tempormandibular disorders?		
91. Do you wear denture(s) or partial denture(s)?		

DO YOU HAVE CONSISTENT PROBLEMS WITH:

	Yes	No
92. Dry mouth / excessive thirst?		
93. Sensitive teeth? Hot Cold Pressure Sweets		
94. Mouth odors / bad taste?		
95. Cold sores / blisters / oral lesions?		
96. Are you aware of any swelling or lumps?		
97. Sore, bleeding gums?		
98. Loose teeth?		
99. Difficulty chewing?		
100. Food catches between teeth?		
101. Teeth / filling break frequently?		
102. Clenching or grinding habits?		
103. Do you hear popping, clicking or snapping?		
104. Do you have jaw pain?		
105. Are you nervous about dental work?		

Work: _____

Who can we contact in the event of an emergency? _____ Home: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Patient's Signature Date	Patient's Signature Date
Patient's Signature Date	Patient's Signature Date
Patient's Signature Date	Patient's Signature Date
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