PATIENT INFORMATION

Name: | Birth Date: | Age:

Address: | Social Security:

City: | State: | Zip: | Home Phone #:

Employer: | Work Phone #:

Occupation: | Cell Phone #:

Marital Status: Single Married Divorced Widowed | Email:

SPOUSE/PARENT/GUARDIAN INFORMATION:

Name: | Birth Date: | Age:

Address: | Social Security #:

City: | State: | Zip: | Home Phone #:

Employer: | Work Phone #:

Occupation: | Cell Phone #:

Are you a seasonal resident? :

☐ Yes ☐ No | **Closest relative not living with you:**

Address: | Name: | Relationship:

City: | State: | Zip: | Address:

Home Phone #: | City: | State: | Zip:

Home Phone #:

Do you know anyone who has been treated in our office?

☐ Yes ☐ No Whom? : | **Who referred you to our office? :**

DENTAL INSURANCE INFORMATION:

Company: | Subscriber's Name:

Address: | Date of birth:

City: | State: | Zip: | ID#:

Phone #: | Group#:

Patient Responsibility: All professional services rendered are charged to the patient or responsible party. Necessary forms will be completed to expedite insurance carrier's payment. If Thomas G. Rubino, D.D.S., M.S., P.A., retains the services of an attorney or collection agency because my account has become delinquent, I agree to pay all costs of collections including, but not limited to, attorney's fees, court costs, paralegal fees, collection fees and costs, and attorney's fees incurred on appeal or in bankruptcy.

Insurance Authorization: I hereby authorize Dr. Rubino to furnish information to my insurance carriers concerning my treatments, and I hereby assign to them all payments for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance.

SIGNATURE ON FILE | DATE

HEALTH HISTORY:

1. Are you having any pain or discomfort at this time? ☐ Yes ☐ No
2. Are you nervous about having dental treatment? ☐ Yes ☐ No
3. Have you ever had a bad experience in a dental office? ☐ Yes ☐ No

IN THE LAST TWO YEARS HAVE YOU:

4. Been a patient in the hospital? ☐ Yes ☐ No
5. Been under the care of a medical doctor? ☐ Yes ☐ No

Physician's Name: | Phone #:

Pharmacy Name: | Phone #:

7. Are you taking any medications, drugs, pills or aspirin? ☐ Yes ☐ No
   If yes, please list: _____
8. List previous surgeries: _____
9. Have you ever had trouble with anesthesia? ☐ Yes ☐ No
   Please Describe: _____
10. Have you ever had cancer or a tumor? ☐ Yes ☐ No Chemotherapy or Radiation Therapy? ☐ Yes ☐ No
11. Have you ever taken any medications for osteoporosis? ☐ Yes ☐ No
12. Are you allergic or have reacted adversely to any medications? ☐ Yes ☐ No
    If yes, list the name of medication(s): _____
13. Check any of the following boxes which you have had or have at present:

☐ Heart Disease or Attack ☐ Angina Pectoris ☐ Diabetes ☐ Hepatitis ☐ Hemophilia
☐ High Blood Pressure ☐ Epilepsy/Seizures ☐ HIV/AIDS ☐ Cold Sores/Fever Blisters

Uncontrolled gum disease can increase your risk for heart attack and stroke.

Gum disease is a common complication of diabetes. Untreated gum disease makes it hard for diabetics to control their blood sugar.

Ulcers are caused by bacteria. When your gums are inflamed, bacteria from the mouth can travel to the stomach and cause ulcers to become active. If you have been treated for ulcers you should make sure your gums are as free of inflammation as possible.

14. Do you premedicate with antibiotics for dental appointments?: ☐ Yes ☐ No
    If yes, with what antibiotic? _____ and for which of the following? :

☐ Artificial Heart Valve ☐ Artificial Joints (Hip, Knee) ☐ Heart Murmur ☐ Rheumatic Fever
☐ Heart Pacemaker ☐ Mitral Valve Prolapse ☐ Scarlet Fever ☐ Heart Surgery

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and cause a serious infection of the heart muscle or your artificial joint.

15. Do you use tobacco products? ☐ Yes ☐ No
16. Do you use alcohol? ☐ Yes ☐ No

Tobacco use is the most significant risk factor for gum disease.

17. List any other disease, condition or problem that you may have: _____

FOR WOMEN ONLY:

18. Are you pregnant? ☐ Yes ☐ No If yes, what trimester? _____
19. Are you taking birth control pills? ☐ Yes ☐ No

Females can be at an increased risk for gum disease at different points in their life.

There is a higher incidence of low birth weight and preterm births when the mother has periodontal disease/gum problems.

DENTAL HISTORY:

20. Dentist's name: _____ How long? : _____
21. How many times a year do you have your teeth cleaned? : _____ Date of last cleaning: _____
22. Do you floss daily? ☐ Yes ☐ No
23. How/who made you aware of a concern in your mouth? : _____
24. Please make any additional comments you feel we should know: _____

The tendency for gum disease to develop can be passed on to family members

The bacteria which causes gum disease may be spread to a spouse or the family

25. Have you noticed any of the following signs of gum disease? :

☐ Bleeding gums during brushing ☐ Pus between the teeth and gums ☐ Persistent bad breath
☐ Red, swollen or tender gums ☐ Loose or separating teeth ☐ Food catching between teeth
☐ Gums that have pulled away from the teeth ☐ Change in the way your teeth fit together

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____