STEFANO DENTAL

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PLEASE COMPLETE BOTH SIDES OF FORM

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Other/Cell):_____

E-mail:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Patient's Employer/School: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Spouse/Parent's Name: _____Spouse/Parent's Birth Date: _____

Spouse/Parent's Social Security # _____Spouse/Parent's Employer: _____

Who is responsible for this account? _____

Relationship to Patient? _____ Does patient have dental insurance? Yes No

Name and birth date of insured/subscriber_____

Name and Phone # of dental insurance company_____

Insured's ID #_____Group #_____ Claims Mailing Address_____

Is patient covered by secondary dental insurance? Yes No _____

Name and birth date of insured/subscriber_____

Name and Phone # of secondary insurance_____

Insured's ID #_____Group #_____

Claims Mailing Address _____

Referral Information

Whom may we thank for referring you to our practice? _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Bones/Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease/Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches/Migraines
- ☐ HIV+/AIDS
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease/Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Organ Transplant
- ☐ Pace maker
- ☐ Pregnant—Due Date:_____
- ☐ Pneumocystitis
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit--
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Allergy- Aspirin
- ☐ Allergy- Codeine
- ☐ Allergy- Dental Anesthetics
- ☐ Allergy- Erythromycin
- ☐ Allergy- Jewelry
- ☐ Allergy- Latex
- ☐ Allergy- Metals
- ☐ Allergy- Penicillin
- ☐ Allergy- Tetracycline
- ☐ Allergy- Medications

_____

_____

- ☐ Allergy to Other Items

_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- List any medications, herbal supplements, or vitamins you are now taking: _____

  _____

  _____

  _____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have, or have you had any health problems or surgeries, such as joint replacements, heart transplant ☐ Yes ☐ No

  If yes, please explain: _____

Preferred Pharmacy _____

Dr. Initials: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____Date:_____ Relationship to patient_____

Signature of patient, parent or guardian **Updated 02/07/2018**