Dr. Gene A. Anzalone Family Dentist

Patient Name_____ Today's Date_____

Address _____ City_____Zip_____Gender_____

SS#_____ Date of Birth_____Age_____Single Married Domestic Partner

Phone h_____w_____c _____

Occupation_____Email _____

Whom may we thank for referring you to us? _____

Do you have a family member that sees us?_____

Physician's Name _____ Last physical examination_____

Prior Dentist_____ Last dental exam_____Last dental xrays_____

Have you ever had a bad experience in a dental office? Y N
Do you feel nervous about having dental treatment? Y N
Is there anything you dislike about your smile? Y N
Is there anything you would like to speak with the doctor about in private? Y N
Have you been hospitalized within the past two years? Y N
Have you taken any medication or drugs in the past two years? Y N
Are you taking any vitamins, herbal supplements, or "cures?" Y N

INSURANCE INFORMATION
Primary Carrier
Name of Insured _____SS#_____

Relation to patient _____

DOB_____ Employer_____

Carrier_____Group Policy #_____

Secondary Carrier
Name of Insured _____SS#_____

Relation to patient _____

DOB_____ Employer_____

Carrier_____Group Policy #_____

RESPONSIBLE PARTY (If patient is a minor)

Name _____ Relation_____

Address _____

Phone numbers Home_____Work_____Cell_____

Have you ever had excessive bleeding requiring special treatment? Y N
Are there any sores or any growths in your mouth now? Y N
Have you been told you have gum problems? Y N
Have you ever seen a (gum specialist) periodontist? Y N
Women
Are you pregnant? Y N
Are you breastfeeding? Y N
Are you taking oral contraceptives? Y N

Allergies

Aspirin	Y N	Local Anesthetic	Y N	Please list mediations you are currently taking
Barbiturates	Y N	Penicillin	Y N	
Codeine	Y N	Sulfa	Y N	_____
Iodine	Y N	Metals	Y N	
Latex	Y N	Other_____		_____

Do you have/previously had, currently taking/previously taken medication for any of the following:

Chest Pain	Y N	Shortness of Breath	Y N	Hives or Skin Rash	Y N
Heart Problems	Y N	Emphysema	Y N	Kidney Trouble	Y N
Heart Surgery	Y N	Cold Sores	Y N	Hemophilia	Y N
*Congenital Heart Problems	Y N	Oral Herpes	Y N	Angina Pectoris	Y N
Liver Disease/Jaundice	Y N	Lung Disease	Y N	Glaucoma	Y N
High Blood Pressure	Y N	Fainting or Dizzy Spells	Y N	*Steroid Treatment	Y N
Eating Disorder	Y N	Arthritis	Y N	Epilepsy or Seizures	Y N
*Any type of Implant	Y N	Fosomax	Y N	*Use of FenPhen	Y N
*Any type of Transplant	Y N	Persistent Cough	Y N	Tuberculosis (TB)	Y N
*Artificial Joint	Y N	Asthma	Y N	HIV+	Y N
Sinus Trouble	Y N	Mental Retardation	Y N	Use of Tobacco Products	Y N
Sickle Cell Disease	Y N	Hepatitis A B C Other	Y N	Bruise Easily	Y N
Thyroid Disease	Y N	Drug Addiction	Y N	Dentures or Partials	Y N
Anemia	Y N	Alcoholism	Y N	Bisphosphonate Treatment	Y N
Blood Transfusion	Y N	Ulcers	Y N		
Psychiatric Treatment	Y N	Diabetes	Y N		
Radiation/Chemo Therapy	Y N				

Please indicate with a checkmark any jaw related problems
Clicking Pain in or around your ears Difficulty opening or closing Difficulty chewing
TMJ/TMD Habitual Clenching or Grinding History of Trauma to your jaw

Please indicate with a check mark if you are currently experiencing
Swelling in your mouth Bad taste in your mouth Loose tooth or teeth
Gum Problems Other_____

Please indicate with a checkmark any sensitivity to
Hot Cold Sweet Biting/Pressure

I certify I have read and understand the above information. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist the benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for rendered services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

Patient/Parent Signature _____ Date_____