Dr. Infantino and staff are pleased to welcome you to our practice. We look forward to working with you in maintaining your dental health.

Patient Information

Name____Soc.Sec.#_____________________
Last Name *First Name* *Initial*

Address____

City__________________________State________Zip____________Home Phone_____________________

Cell Phone_________________ Work Phone________________ Email__________________________________

Sex M F Birthdate________________________ Single Married Widowed Separated Divorced

Employer____Occupation________________________________

Whom may we thank for referring you? ____

Notify in case of emergency______________________________ Phone Number_______________________

Dental Insurance

Person Responsible for Account____

Relationship to Patient______________ Birthdate________________ Soc.Sec.#_____________________

Address(*if different from patient*)____

Person Responsible Employed by_______________________ Insurance Company___________________

Insurance Company Phone#__________________________Subscriber ID#_________________________

Group#_______________________ Secondary Insurance(*if applicable*) _____________________________

Subscriber Name____ Relation to Patient__________________

Subscriber ID#___________________________Group#________________Phone#___________________

Dental History

What would you like us to do today? ______________________________Are you in dental discomfort today?____

Former Dentist______________________________ Date of last dental care__________________________
How often do you brush?____________________________________ How often do you floss?_________________
Check (√) yes or no if you have had problems with any of the following:

Please complete both sides.

☐ Y ☐ N Bad breath ☐ Y ☐ N Food collection in teeth ☐ Y ☐ N Periodontal treatment
☐ Y ☐ N Bleeding gums ☐ Y ☐ N Grinding or clenching ☐ Y ☐ N Sensitivity to cold
☐ Y ☐ N Clicking or popping jaw ☐ Y ☐ N Loose teeth/broken fillings ☐ Y ☐ N Sensitivity to hot
☐ Y ☐ N Sensitivity to sweets ☐Y ☐ N Sensitivity when biting ☐ Y ☐ N Sores or growths in mouth

Medical History

Physician's Name____Phone_________________________________

Date of last visit___________________ Have you had any serious illnesses or operations? ☐ Y ☐ N If yes, describe______________

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, approximate dates____

Have you ever taken Fen-Phen/Redux? ☐Y ☐N Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control? ☐Y ☐N

Check (√) yes or no whether you have had any of the following:
☐Y ☐N AIDS/HIV Positive ☐Y ☐N Cough, persistent ☐Y ☐N High Blood Pressure ☐Y ☐N Shingles
☐Y ☐N Anaphylaxis ☐Y ☐N Cough up blood ☐Y ☐N Jaw pain ☐Y ☐N Shortness of breath
☐Y ☐N Anemia ☐Y ☐N Diabetes ☐Y ☐N Kidney disease ☐Y ☐N Skin rash
☐Y ☐N Arthritis, Rheumatism ☐Y ☐N Epilepsy ☐Y ☐N Liver disease ☐Y ☐N Spina bifida
☐Y ☐N Artificial joints ☐Y ☐N Fainting ☐Y ☐N Material allergies ☐Y ☐N Stroke
☐Y ☐N Asthma ☐Y ☐N Food allergies ☐Y ☐N Mitral valve prolapse ☐Y ☐N Surgical implant
☐Y ☐N Atopic(allergy prone) ☐Y ☐N Glaucoma ☐Y ☐N Swelling ankles or feet ☐Y ☐N Thyroid disease
☐Y ☐N Back problems ☐Y ☐N Headaches ☐Y ☐N Nervous problems ☐Y ☐N Tobacco habit
☐Y ☐N Blood disease ☐Y ☐N Pace maker/heart surgery ☐Y ☐N Cancer ___________ ☐Y ☐N Psychiatric care
☐Y ☐N Tonsillitis ☐Y ☐N Heart murmur ☐Y ☐N Heart problems ☐Y ☐N Chemical dependency
☐Y ☐N Hemophilia ☐Y ☐N Rapid weight loss or gain ☐Y ☐N Tuberculosis ☐Y ☐N Chemotherapy
☐Y ☐N Radiation treatment ☐Y ☐N Ulcer/colitis ☐Y ☐N Circulatory problems ☐Y ☐N Herpes
☐Y ☐N Respiratory disease ☐Y ☐N Venereal disease ☐Y ☐N Cortisone treatments ☐Y ☐N Hepatitis
☐Y ☐N Rheumatic/Scarlet fever Is the patient currently taking any medications? If yes, list all:______________________________

Does the patient have drug allergies? If yes, list all:____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____Date________________________________
Payment is due in full at time of treatment, unless prior arrangements have been approved.

Please complete both sides.

Please complete both sides.