Last Name _____ First name _____ Birth date _____

Home address _____ Home phone _____

_____ Business phone _____

Referring Dentist _____

Physician _____ Phone _____

Emergency Contact _____ Phone _____

MEDICAL HISTORY

Please answer the following, and if yes indicate with a check mark (✓). Please explain.

____ Have you had any recent prolonged Illness? _____

____ Are you presently under the care of a physician? _____

____ Are you now using any medications? _____

____ Are you sensitive or allergic to any medications or drugs? _____

_____

Are you sensitive or allergic to iodine? ❒ Yes ❒ No

Are you sensitive or allergic to latex? ❒ Yes ❒ No

____ Have you ever had any problems with dental treatment? _____

____ (Women) Are you pregnant? _____

____ Are you currently taking bisphosphonate (i.e. Fosamax)? _____

Do you have or have you had any of the following:

_____ Heart disease
_____ Heart attack
_____ Heart murmur
_____ Heart valve replacement
_____ Prosthetic appliance {hip, knee, etc.)
_____ Angina pectoris
_____ High blood pressure
_____ Kidney disease
_____ Stroke

_____ Glaucoma
_____ Diabetes
_____ Epilepsy
_____ Convulsions
_____ Dizziness or fainting
_____ Asthma
_____ Sinus trouble
_____ A.I.D.S.

_____ Venereal disease
_____ Ulcer
_____ Bleeding problems
_____ Problems healing
_____ Liver disease
_____ Alcoholism
_____ Hepatitis
_____ Psychiatric care (currently)

Other health condition(s)
of which we should be aware: _____

I confirm as true the above health history information and give consent to agreed upon dental services and use of appropriate methods thereto in my behalf.

(Signed) _____ Date: _____
(Patient, Parent, or Guardian)

(Signed) _____ Date: _____
(Dr. Paul Vignaroli)

PATIENT _____

Patient or Parent

Employer _____

Address _____

Phone ( ) _____ Ext _____

Drivers License# _____ DOB _____

Spouse or Parent Name _____

Employer _____

Address _____

Phone ( ) _____ Ext _____

Drivers License# _____ DOB _____

PLEASE PROVIDE US WITH THE FOLLOWING DENTAL INSURANCE INFORMATION:

Social Security # _____

Dental Ins. Co. _____

Address _____

_____

Phone ( ) _____

Group# _____ Policy# _____

Union Local _____

Social Security # _____

Dental Ins. Co. _____

Address _____

_____

Phone ( ) _____

Group# _____ Policy# _____

Union Local _____

I hereby authorize my insurance benefits to be paid directly to the office of Dr. P.A. Vlgnaroli. I am financially responsible for non-covered services. I also authorize this office to release any information required about my dental condition/treatment needed to determine benefits for up to five years from this date.

(Signed) _____ Date: _____
(Patient, Parent, or Guardian)

FOR OFFICE USE ONLY

Date _____

Max _____

Ded _____

Prevent _____

Endo _____

Major _____

UCR/Fee Sch _____

Amt. Used _____

Name _____

Date _____

Max _____

Ded _____

Prevent _____

Endo _____

Major _____

UCR/Fee Sch _____

Amt. Used _____

Name _____