Welcome

Dr. Freano and his staff would like to thank you for choosing our office for your dental needs. We look forward to providing you with exceptional dental care and working with you to achieve superior oral health.

Patient Information (CONFIDENTIAL)

Date_____

Name_____Birthdate_____SS#_____
Address_____City_____State_____Zip_____
Home Phone_____Work Phone_____Cell Phone_____
Employer_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Email_____
Are any immediate family members already a patient in the office? _____
Whom May We Thank for Referring You?_____
Spouse or Parent/Guardian's Name_____
Employer_____Work Phone_____Cell Phone_____
Person to Contact in Case of Emergency_____Phone_____
If Student, Name of College_____City_____State_____ ☐ Full Time ☐Part Time

Responsible Party

Name of Person Responsible for this Account_____Relationship_____
Birthdate_____SS#_____
Address_____Home Phone_____
Email_____Cell Phone_____May we call you here? ☐ Yes ☐ No
Employer_____Work Phone_____
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured_____Relationship to Patient_____
Birthdate_____SS#_____Date Employed_____
Name of Employer_____Union/Local #_____Work Phone_____
Insurance Company_____Group #_____Policy/ID #_____
Ins. Co. Address_____City_____State_____Zip_____
Phone Number_____

Do You Have Any Secondary Insurance? ☐ Yes ☐ No If Yes, Complete the following:

Secondary Insurance Information

Name of Insured_____Relationship to Patient_____
Birthdate_____SS#_____Date Employed_____
Name of Employer_____Work Phone_____
Insurance Company_____Group #_____Policy/ID #_____
Ins. Co. Address_____City_____State_____Zip_____
Phone Number_____

Over Please

Dental History

Reason for today's visit_____ Date of last dental cleaning_____

Date and purpose of last dental visit_____

Former Dentist_____

What are you looking for in a dental care provider?_____

How often do you brush?_____ How often do you floss?_____

Have you recently or are you now experiencing any dental pain?_____

Have you ever been told you suffer from TMJ?_____

What is the one thing you would change about your smile if you could?_____

_____

Clicking/popping jaw	☐ Yes	☐ No	Are you pleased with your smile?	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Have you bleached your teeth in the past?	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Do you catch food between the teeth?	☐ Yes	☐ No
Dental Phobia	☐ Yes	☐ No	Sensitive to cold/hot/sweets?	☐ Yes	☐ No
			Orthodontic Treatment	☐ Yes	☐ No

Medical History

Medical doctor's name _____ phone number _____

Please indicate if you have ever been treated for any of the following conditions:

	Yes	No		Yes	No	Date
AIDS/HIV	☐	☐	AV Shunt	☐	☐	_____
Anemia	☐	☐	Cancer	☐	☐	_____
Congenital Heart Defect	☐	☐	Heart Attack	☐	☐	_____
Congestive Heart Failure	☐	☐	Joint Replacement	☐	☐	_____
Diabetes	☐	☐	Oral Radiation	☐	☐	_____
Heart Murmur	☐	☐	Organ Transplant	☐	☐	_____
Hepatitis	☐	☐	Rheumatic Fever	☐	☐	_____
High Blood Pressure	☐	☐	Stroke	☐	☐	_____
Mitro Valve Prolapse	☐	☐	Tuberculosis	☐	☐	_____
Psychiatric Care	☐	☐				

Have you ever been told that you need to pre-medicate prior to dental appointments?_____

If you are female, are you currently pregnant or nursing?_____

Do you use tobacco products?_____

Please list any hospitalizations or major surgeries:_____

_____

Does your family have a history of heart disease? _____

Have you ever had a medical problem associated with any dental experience?_____

_____

Do you have any other condition/problem not previously listed that you feel we should know about?

_____

Medications (Check all medications you are currently taking)

☐ Antibiotics	☐ Blood Thinners	☐ Other (please list):_____
☐ Antidepressants (Prozac, Zoloft)	☐ Heart Medicine	_____
☐ Birth Control	☐ Pain Control	_____

Allergies (Check all that apply)

☐ Aspirin	☐ Local Anesthetic (Novocaine)	☐ Other (please list):_____
☐ Codeine	☐ Penicillin	_____
☐ Latex	☐ Sulfa	_____