



D. Scott Trettenero, DDS

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(239) 277-7007 • www.AllSmilesNow.Com

PATIENT INFORMATION (Confidential)

Please provide your driver license and dental insurance card to copy and have on file. Thank you.

Today's Date _____ Name _____ Birth date _____

Address _____ City _____ State _____ Zip Code _____

Marital Status: Single Married Divorced Widowed E-Mail _____

Telephone _____ Cell Phone _____

Employer Name _____ Business Telephone _____

How did you hear about our office? Newspaper Online Patient Other _____

Person to Contact in an Emergency? _____ Telephone _____

RESPONSIBLE PARTY Check box if information same as above

Name of Responsible party for this Account _____ Birth date _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ Cell Phone _____ Work Phone _____

Employer Address _____ City _____ State _____

Relationship to Patient _____ Is this Party Currently a Patient at our Office? Yes No

INSURANCE INFORMATION *If you have dental insurance, please fill out the following information*

Name of Primary Insurance Holder _____ Social Security Number _____

Primary Insurance Holder Date of Birth _____ Policy Holder Address _____

Insurance Company Name _____ Insurance ID _____ Group Number _____

Insurance Company Address _____ City _____ State _____ Zip Code _____

Name of Employer _____ City _____ State _____ Zip Code _____

CANCELATION POLICY

If you cancel or do not show up for an appointment without 24 hour notice twice, our office reserves the right to have you pre pay for all future appointments. *Initial* _____

RELEASE OF RECORDS

When releasing dental records, there can be fee of \$25.00 after a signed release is received by our office. *Initial* _____

Patient Signature Date

PATIENT MEDICAL HISTORY *(Please fill this form out completely)*

Medical Physician's Name _____ Telephone _____ Last Exam Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could be important and interrelated with the dentistry that you will be receiving. Thank you for answering the following questions.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Are you in overall good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health in the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had any heart procedures or surgeries within the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you need to pre-medicate for any dental procedures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have or had a drug, alcohol, or any other drug addiction or abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you currently or have taken Bisphosphonates? (Fosomax, Actonel, Boniva, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you taking medication, including non prescription drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
- IF YES, PLEASE LIST THEM (or we can make a copy) _____

Are you allergic to any of the following?

- | Yes No | Yes No | Yes No |
|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Local Anesthetic's | <input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> <input type="checkbox"/> Steroids |
| <input type="checkbox"/> <input type="checkbox"/> Codeine | <input type="checkbox"/> <input type="checkbox"/> Iodine | <input type="checkbox"/> <input type="checkbox"/> Aspirin |

If you have any other allergies please list them: _____

Do you have any of the following health conditions?

- | Yes No | Yes No | Yes No |
|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> <input type="checkbox"/> Dementia | <input type="checkbox"/> <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Easily Winded | <input type="checkbox"/> <input type="checkbox"/> MRSA Infection |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Convulsions | <input type="checkbox"/> <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Radiation |
| <input type="checkbox"/> <input type="checkbox"/> Bone Density Problems | <input type="checkbox"/> <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Heart Attack / Heart Trouble | <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Stomach Troubles / Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pains | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Swollen of Limbs |
| <input type="checkbox"/> <input type="checkbox"/> COPD /Emphysema | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> <input type="checkbox"/> Other _____ | | |
|
 | | |
| <input type="checkbox"/> Joint Replacement or Implant Date _____ | Location of Implant _____ | |

DENTAL HISTORY

Do you have any of the following dental conditions?

- | Yes No | Yes No | Yes No |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> <input type="checkbox"/> Sensitivity to hot or cold liquids /foods | <input type="checkbox"/> <input type="checkbox"/> Popping/ clicking of jaw |
| <input type="checkbox"/> <input type="checkbox"/> Pain in jaw joint | <input type="checkbox"/> <input type="checkbox"/> Difficulty opening or closing jaw | <input type="checkbox"/> <input type="checkbox"/> Pain when chewing |
| <input type="checkbox"/> <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> <input type="checkbox"/> Clench your teeth | <input type="checkbox"/> <input type="checkbox"/> Grind your teeth |
| <input type="checkbox"/> <input type="checkbox"/> Had any dental extractions | <input type="checkbox"/> <input type="checkbox"/> Had any orthodontic work | |
| <input type="checkbox"/> <input type="checkbox"/> Had injury to your head, neck, or jaw | | |

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand that answering incorrectly can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me/ spouse / child during my dental care to third party payers' and or health practitioners. Any unpaid balance that is 60 days or over is subject to a 3% monthly interest rate. Any unpaid balances after 120 days, the balance will be turned over to collections. I agree to be responsible for payment for all services rendered on my behalf or dependents.

Signature _____ Date _____