D. Scott Trettenero, DDS
13440 Parker Commons Boulevard #104 • Fort Myers • FL • 33912
(239) 277-7007 • www. AllSmilesNow. Com

PATIENT INFORMATION (*Confidential)*

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

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*_____

DENTAL HISTORY

Do you have any of the following dental conditions?

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

PATIENT MEDICAL HISTORY

Patient Name: _____ _____

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. This will need to be updated on a yearly basis. Thank you for answering the following questions.

(Please Check Yes or No)	Yes	No
1. Are you in overall good health?	□	□
2. Have there been any changes in your general health in the last year?	□	□
3. Have you had any heart procedures or surgeries within the last year?	□	□
If ***YES***, please explain: _____		
4. Do you need to pre-medicate for any dental procedures?	□	□
5. Are you currently or have taken Bisphosphonates? (Fosamax, Actonel, Boniva, Prolia, etc.)	□	□
7. Are you taking medication, including nonprescription drugs?	□	□

IF YES, PLEASE LIST THEM (or we can make a copy of them) _____

_____

Are you allergic to any of the following? ***(Please Check Yes or No)***

Yes	No		Yes	No		Yes	No	
□	□	Local Anesthetic's	□	□	Penicillin or other antibiotics	□	□	Steroids
□	□	Aspirin	□	□	Codeine	□	□	Iodine

If you have any other allergies, please list them: _____

Do you have or had any of the following health conditions? (PLEASE CHECK YES OR NO TO ALL)

Yes	No		Yes	No		Yes	No	
□	□	Acid Reflux	□	□	CPAP Machine	□	□	Low Blood Pressure
□	□	AIDS/ HIV	□	□	Diabetes	□	□	Macular Degeneration
□	□	Alzheimer's	□	□	Dementia	□	□	Mitral Valve Prolapse
□	□	Anemia	□	□	Dizziness / Fainting	□	□	MRSA Infection
□	□	Arthritis	□	□	Epilepsy / Convulsions	□	□	Parkinson's Disease
□	□	Asthma	□	□	Glaucoma	□	□	Radiation
□	□	Bone Density Problems	□	□	Hearing Loss	□	□	Respiratory Problems
□	□	Cardiac Pacemaker	□	□	Heart Attack / Heart Trouble	□	□	Rheumatoid Arthritis
□	□	Cardiac Defibrillator	□	□	Heart Murmur	□	□	Sexually Transmitted Diseases
□	□	Cancer	□	□	Hepatitis / Jaundice	□	□	Stomach Troubles / Ulcers
□	□	Chemotherapy	□	□	High Blood Pressure	□	□	Stroke
□	□	Chest Pains	□	□	Kidney Dialysis	□	□	Swelling of Limbs
□	□	COPD /Emphysema	□	□	Liver Disease	□	□	Thyroid Disease

□ Other Health Conditions: _____

□ Joint Replacement Date and Location_____

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 _____