Vezzetti Family Dental Care

## About You:

Name: _____ ☐ Female ☐ Male

Birth Date: ___/___/___ Marital Status: Single, Married, Widowed, Divorced

Social Security#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

E-Mail Address: _____

Names of Family Members: _____

_____

Last Dental Visit: _____ Last Dental X-Rays: _____

Last Dentist: _____

Who can we thank for referring you? _____

## Emergency Information:

Person to contact: _____

Relationship: _____

Phone: _____

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you. Thank you!

## Insurance Information:

Policy Holder: _____

Policy Holder's birth date: ____/____/____

Policy Holder's SS#: _____

Policy Holder's employer: _____

Insurance company name: _____

Insurance Company Phone Number: _____

Group#: _____

Member ID: _____

**I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Dr. Mary Vezzetti.** **Pt.Initials:_____**

# *Vezzetti Family Dental Care*

## Medical History

**Name:** _____ **Date:** _____

Name of personal physician: _____ _ Drs. Phone Number: _____

Have you been hospitalized in the last five years? If yes, please explain: _____

_____

(For women) Are you currently pregnant? ☐Yes ☐No If yes, how many months? _____

Do you have Acid Reflux? ☐ Yes ☐ No

Please list **ANY** medications, pills, vitamins or drugs you are taking: _____

_____

Do you require to be Pre-Medicated for dental appointments? ☐Yes ☐No Do you use tobacco? ☐Yes ☐o

## Please check if you're allergic to any of the following:

☐Local anesthetics ☐Sulfa drugs ☐Codeine ☐Penicillin ☐Acrylic ☐Aspirin ☐Metal ☐Latex

☐ Other (If yes explain) _____

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

| | | | |
|---|---|---|---|
| ☐AIDS/HIV Positive | ☐Drug Addiction | ☐Hepatitis B or C | ☐Rheumatism |
| ☐Alzheimer's disease | ☐Easily Winded | ☐Herpes | ☐Scarlet Fever |
| ☐Anaphylaxis | ☐Emphysema | ☐High Blood Pressure | ☐Shingles |
| ☐Arthritis/Gout | ☐Epilepsy or seizures | ☐Hives or Rash | ☐Sickle Cell Disease |
| ☐Artificial Heart Valve | ☐Excessive Bleeding | ☐Hypoglycemia | ☐Sinus Trouble |
| ☐Artificial Joint | ☐Excessive Thirst | ☐Irregular Heartbeat | ☐Spinal Bifida |
| ☐Asthma | ☐Fainting Spells/Dizziness | ☐Kidney Problems | ☐Stomach Disease |
| ☐Blood Disease | ☐Frequent Cough | ☐Leukemia | ☐Stroke |
| ☐Blood Transfusion | ☐Frequent Diarrhea | ☐Liver Disease | ☐Swelling of Limbs |
| ☐Breathing Problem | ☐Frequent Headaches | ☐Low Blood Pressure | ☐Thyroid Disease |
| ☐Bruise Easily | ☐Genital Herpes | ☐Lung Disease | ☐Tonsillitis |
| ☐Cancer | ☐Glaucoma | ☐Mitral Valve Prolapse | ☐Tuberculosis |
| ☐Chemotherapy | ☐Hay Fever | ☐Pain in Jaw Joints | ☐Tumors or Growth |
| ☐Chest Pains | ☐Heart Attack/Failure | ☐Parathyroid Disease | ☐Ulcers |
| ☐Cold Sores/Fever Blisters | ☐Heart Murmur | ☐Psychiatric Care | ☐Venereal Disease |
| ☐Congenital Heart Disorder | ☐Heart Pace Maker | ☐Radiation Treatments | ☐Yellow Jaundice |
| ☐Convulsions | ☐Heart Trouble/Disease | ☐Recent Weight Loss | |
| ☐Cortisone Medicine | ☐Hemophilia | ☐Renal Dialysis | |
| ☐Diabetes | ☐Hepatitis A | ☐Rheumatic Fever | |

Have you ever had any serious illness not listed above? If yes, please explain: _____

_____

*The information that I have given is true and accurate to the best of my knowledge.*

**Signature**: _____ **Date**: _____

# *Vezzetti Family Dental Care*

## *Communication of Health Information Authorization and Appointment Reminder*

I _____, _____ authorize Vezzetti Family Dental Care to
Patient first name, last name, middle initial Date of birth

Contact me via the following methods:

Please check the appropriate boxes – checking a box gives us permission to leave health information (i.e. test results, prescription refills, appointment and billing information.)

| Ways to Communicate Health Information | Leave message on answering machine: | Leave message with whoever answers telephone: | For incoming phone calls – You may release information to the following:<br>Name Relationship Date of birth |
|---|---|---|---|
| Home phone<br>( ) _____-_____ | ☐ | ☐ | _____<br>_____<br>_____ |
| Work phone<br>( ) _____-_____ | ☐ | ☐ | _____<br>_____<br>_____ |
| Cell phone<br>( ) _____-_____ | ☐ | ☐ | _____<br>_____<br>_____ |
| Fax ( ) _____ ☐ Approved | | | Letter ☐ Approved |

Unless otherwise requested, we may remind you of an upcoming appointment by letter, a telephone call, a text message, a message on your answering machine or voicemail, or a message with the person who answered your telephone. Appointment reminders will include the date and time of your appointment, the provider you are schedule to see and the medical center location. I understand that this will authorize the release of my information in the manner stated above. **I understand a written notification is necessary to cancel this request.**

_____ _____ _____
Signature Relationship if not patient Date

I am giving permission for Vezzetti Family Dental Care to administer medical treatment to my minor child _____ without my presence.

This consent will remain in effect until further notice is given in writing.

_____ _____
Guardian Signature Date