Jeffrey A. Cavalancia, DDS, MSD – *Practice limited to orthodontics*

Patient Information and Health History

Patient's Name:

Last: _____First:_____MI:____ Date of Birth:_____ (xx/xx/xxxx)

Address: _____ Gender: _____Male _____Female

Address2: _____ Home Phone: _____

City: _____ Dentist: _____

State: _____ Zip:_____ Family Physician: _____

Whom may we thank for referring this patient to our office? _____

Chief dental complaint:_____

Date of last complete Dental Exam: _____

How often does the patient clean his/her teeth? _____ Does the patient floss? ____ Yes ____ No

Date of last Physical Exam: _____ Is the patient currently under a physician's care? ____ Yes ____ No

May I consult the patient's Physician/Dentist about the patient? ____ Yes ____ No

Is the patient taking any prescriptions or over-the-counter drugs/medications? ____ Yes ____ No

If so, list: _____

Does the patient have or has he/she had allergies to medications? ____ Yes ____ No

If so, list: _____

Does the patient have or has he/she had allergies to anesthetics? ____ Yes ____ No

If so, list: _____

Does the patient have or has he/she had allergies (i.e.: Latex, food, seasonal)? ____ Yes ____ No

If so, list: _____

Does the patient have or has he/she had any of the following? *(please check - Y=Yes; N=No)*

___ Y ___N Asthma	___ Y ___N Cortisone	___ Y ___N Liver Trouble
___ Y ___N Shortness of Breath	___ Y ___N Blood Thinner	___ Y ___N Kidney Trouble
___ Y ___N Lip Fever Blisters	___ Y ___N Thyroid Problem	___ Y ___N High Blood Pressure
___ Y ___N Breath Odors	___ Y ___N Major Surgery	___ Y ___N Headaches
___ Y ___N Trenchmouth	___ Y ___N Anemia	___ Y ___N Fainting Spells
___ Y ___N Tooth Sensitivity	___ Y ___N Heart Disease	___ Y ___N Weight Loss
___ Y ___N Food Wedging between Teeth	___ Y ___N Diabetes	___ Y ___N Weight Gain
___ Y ___N High Cholesterol	___ Y ___N Hepatitis	___ Y ___N Chronic Tiredness
___ Y ___N Teeth Straightened	___ Y ___N Arthritis	___ Y ___N Low Blood Pressure
___ Y ___N Clotting Problems	___ Y ___N Rheumatic Fever	___ Y ___N Excessive Thirst
___ Y ___N Bleeding Problems	___ Y ___N Artificial Joints	___ Y ___N Liver Trouble
___ Y ___N Autoimmune Disorder	___ Y ___N Seizures	___ Y ___N Nervous Tension
___ Y ___N Previous Periodontal (Gum) Tx	___ Y ___N HIV	___ Y ___N Stress

If you have answered *"Yes"* to any of the above, please explain: _____

_____

Does the patient have any other medical or dental problems and/or conditions? ____ Yes ____ No

If so, list: _____

Does the patient have any information/x-ray, etc., to bring to us? ____ Yes ____ No

Whom should we contact in an emergency?

Name: _____ Relationship: _____ Phone: _____

Please bring all patient information to the first visit.

office use only

PERIODONTAL: _____ Within Normal Limits Concerns: _____

ORAL CANCER SCREENING: + -

REVIEWED: _____ **DATE:** _____

Patient Financial/Insurance Information

Primary Responsible Party (Patient or Parent/Guardian if Patient is a Minor)

Primary Responsible Party: _____
Relationship: _____
Marital Status: _____S _____M _____D _____W
Address: _____
City: _____ State: ____ Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Employer: _____
Employer Address: _____
Employer City: _____
Employer State: _____ Zip: _____

Date of Birth: _____ (xx/xx/xxxx)
SS#: _____
Medical Insurance Co.: _____
Medical Insurance Co. Phone #: _____
Dental Insurance Co.: _____
Dental Insurance Co. Phone #: _____
Dental Insurance Co. Address: _____
Dental Insurance Co. City: _____
Dental Insurance Co. State: _____ Zip: _____
Subscriber Name: _____
Subscriber ID Number: _____
Group Number: _____
Orthodontic Coverage? ____ Yes ____ No

Secondary Responsible Party (Spouse or Parent/Guardian)

Secondary Responsible Party: _____
Relationship: _____
Marital Status: _____S _____M _____D _____W
Address: _____
City: _____ State: ____ Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Employer: _____
Employer Address: _____
Employer City: _____
Employer State: _____ Zip: _____

Date of Birth: _____ (xx/xx/xxxx)
SS#: _____
Medical Insurance Co.: _____
Medical Insurance Co. Phone #: _____
Dental Insurance Co.: _____
Dental Insurance Co. Phone #: _____
Dental Insurance Co. Address: _____
Dental Insurance Co. City: _____
Dental Insurance Co. State: _____ Zip: _____
Subscriber Name: _____
Subscriber ID Number: _____
Group Number: _____
Orthodontic Coverage? ____ Yes ____ No

INSURANCE: Your signature allows us to bill your insurance company for services rendered.
Any account balance remaining outstanding after insurance has paid is the responsibility of the patient/responsible party.
Monthly statements will be sent to the person who signs below. We reserve the right to check the credit history of any party in default, or those individuals signing this contract.

I certify that the above Patient information is correct to the best of my knowledge and I agree to notify this office of any changes in the Patient's health/financial history during the course of treatment.

Print Name: _____ (Patient or Parent/Guardian if patient is a Minor)
Signature: _____ (Patient or Parent/Guardian if patient is a Minor)
Today's Date: _____ (example: March 1, 2010)
Appointment Date & Time: _____ (example: March 1, 2010 10am)