

Person Responsible for Payment

John M. Conella, D.M.D.

Mr. Mrs. Ms. Dr. _____
Last *MI* *First*

Street Address _____

City _____ State _____ Zip Code _____

Phone # (Home) _____ (Work) _____

If different from patient information { Social Security Number _____ Date of Birth _____
 Employer Name _____
 Employer Address _____

Occupation _____

Insurance Company _____

Insurance Phone Number _____

Group Number _____ Contract Number _____

Have you used your insurance this year? yes no

To the best of my knowledge, the information **above (and below if applicable)** is correct. I understand that where appropriate, credit bureau reports may be obtained. I realize that this office will assist in insurance processing, however all charges are ultimately my responsibility.

Signature (parent's if minor) X _____ Date _____

Spouse or Other Person Responsible for Payment

Name Mr. Mrs. Ms. Dr. _____
Last *M/* *First*

Street Address _____

City _____ State _____ Zip Code _____

Phone # (Home) _____ (Work) _____

Social Security Number _____ Date of Birth _____

Employer Name _____

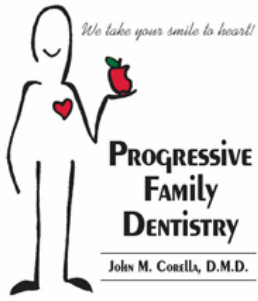
Employer Address _____

Occupation _____

Insurance Company _____

Insurance Phone Number _____

Group Number _____ Contract Number _____



Today's date _____

Medical History

Patient Name: Mr. Mrs. Ms. Dr. _____ Date of birth _____
 Last *M/* *First*

Street Address: _____

City: _____ State _____ Zip Code _____

Phone # (Home) _____ (Work) _____

General Health: Excellent Good Fair Date of last physical _____

Are you under current medical treatment? yes no

If yes, please explain: _____

Are you currently taking any medications? yes no

If yes, please list medications: _____

Do you have any allergies or adverse reaction to drugs? yes no

If yes, please list: _____

Are you on a special diet? yes no

Have you lost or gained more than 10 pounds in the past year? yes no

Do you use any form of tobacco? yes no

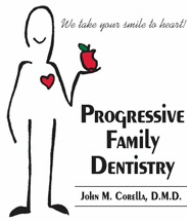
If yes, are you interested in quitting? yes no

Women - (Please check)

Are you: Pregnant Nursing On hormone therapy On birth control medication?

Has a Physician ever informed you that you have or have had any of the following?

- | | |
|--|--|
| Rheumatic Fever <input type="checkbox"/> yes <input type="checkbox"/> no | Respiratory Disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| Heart Murmur <input type="checkbox"/> yes <input type="checkbox"/> no | Intestinal Disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| Mitral Valve Prolapse <input type="checkbox"/> yes <input type="checkbox"/> no | Cancer <input type="checkbox"/> yes <input type="checkbox"/> no |
| Other Heart Ailment <input type="checkbox"/> yes <input type="checkbox"/> no | Chemo/Radiation Therapy <input type="checkbox"/> yes <input type="checkbox"/> no |
| Artificial Joints <input type="checkbox"/> yes <input type="checkbox"/> no | Liver Disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| HIV or Aids <input type="checkbox"/> yes <input type="checkbox"/> no | Kidney Disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| Hepatitis <input type="checkbox"/> yes <input type="checkbox"/> no | Major Operations <input type="checkbox"/> yes <input type="checkbox"/> no |
| Pacemaker <input type="checkbox"/> yes <input type="checkbox"/> no | Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no |
| High Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no | Stroke <input type="checkbox"/> yes <input type="checkbox"/> no |
| Fainting Spells <input type="checkbox"/> yes <input type="checkbox"/> no | Psychological/ |
| Epilepsy <input type="checkbox"/> yes <input type="checkbox"/> no | Psychiatric Treatment <input type="checkbox"/> yes <input type="checkbox"/> no |
| Head Injuries <input type="checkbox"/> yes <input type="checkbox"/> no | Caffeine Dependency <input type="checkbox"/> yes <input type="checkbox"/> no |
| Blood Disorder <input type="checkbox"/> yes <input type="checkbox"/> no | Drug/Alcohol Dependency <input type="checkbox"/> yes <input type="checkbox"/> no |
| Latex Sensitivity <input type="checkbox"/> yes <input type="checkbox"/> no | Organ Transplant <input type="checkbox"/> yes <input type="checkbox"/> no |



Dental History

When was your last cleaning and examination? _____ Your last dental x-ray taken? _____

Who was your previous dentist? _____ Phone _____

What influenced you to change dentists? _____

What is your immediate dental concern? _____

Please check if you have, or ever had the following:

- | | | | |
|--|--------------------------|---|--------------------------|
| 1. Unfavorable dental experiences | <input type="checkbox"/> | 13. An unpleasant taste or odor
in your mouth | <input type="checkbox"/> |
| 2. Dental fears | <input type="checkbox"/> | 14. Viral infection or cold sores | <input type="checkbox"/> |
| 3. Preference for no dental anesthetic | <input type="checkbox"/> | 15. Jaw problems
(temporomandibular joint) | <input type="checkbox"/> |
| 4. Problems with effectiveness or
bad reactions to dental anesthetic | <input type="checkbox"/> | 16. Difficulty opening your mouth widely | <input type="checkbox"/> |
| 5. Orthodontic treatment (braces) | <input type="checkbox"/> | 17. Stiff neck or facial muscles | <input type="checkbox"/> |
| 6. Periodontal (gum) treatment | <input type="checkbox"/> | 18. Awaken with an awareness
of your teeth or jaws | <input type="checkbox"/> |
| 7. Bleeding gums | <input type="checkbox"/> | 19. Tension headaches | <input type="checkbox"/> |
| 8. Habitual chewing of
hard substances, e.g.,
ice, popcorn kernels | <input type="checkbox"/> | 20. Clench or grind your teeth | <input type="checkbox"/> |
| 9. Part of your mouth is sensitive
to temperature | <input type="checkbox"/> | 21. Jaw clicking or popping | <input type="checkbox"/> |
| 10. Lumps or bumps on head or neck | <input type="checkbox"/> | 22. How often do you brush? _____ | |
| 11. A burning sensation in your mouth | <input type="checkbox"/> | 23. How often do you floss? _____ | |
| 12. Difficulty swallowing | <input type="checkbox"/> | 24. Other oral health aids: _____ | |

How important is it for you to keep the rest of your teeth for the rest of your life? (check one):

Not important 1 2 3 4 5 6 7 8 9 10 Very Important

How would you rank your smile? (check one):

Unpleasant 1 2 3 4 5 6 7 8 9 10 Beautiful

If you wear a removable partial or complete denture, please complete the following:

How long have you worn your **present** denture? _____

When did you receive your first partial or complete denture? _____

yes no Is your present denture a problem? Describe _____

yes no Are you satisfied with the appearance? _____

yes no Are you satisfied with the comfort? _____

yes no Are you satisfied with your chewing ability? _____