

BERRY *Hill* DENTISTRY

John Cottone DMD & Carol Anne Schmitz DMD

Please Complete and Return to the Business Office

Personal Information

Name: (Last, First, Middle Initial)					
Address: (Street or P.O. Box, City, State, Zip)				Phone Number: Home: Work:	
Pager #:		Cell Phone:		Email Address:	
Age: (Years)	Date of Birth: (Month/Day/Year)		Birthplace:		() Married () Unmarried () Separated
Social Security #: (if child, parents)			Driver's License #:		
Occupation:		Employer:		How long employed?	Address & Phone #:
Person Responsible for Bill:		Age:	Address:		Relationship: Social Security #: Driver's License #:
Occupation:		Employer:		How long Employed?	
Employer Address & Phone No:					

Insurance Information

Insured Person's Full Name		
Date of Birth		
Social Security Number	Relationship to Patient	Work Phone
Insurance Company Name	Group or Union Name	Group or Local Numbers
Employer's Name		Full Address of Employer

Getting to Know You

1. Why did you select our practice? _____ _____	5. When was your last dental visit? _____
2. Whom may we thank for referring you? _____	6. When was the last time you had complete dental radiographs taken? _____ Name and Address of last Dentist: _____
3. Is another member of your family or relative a patient in our practice? _____	7. Have you ever had any teeth removed? _____ How long have these teeth been missing? _____ Have these teeth been replaced? _____ How? <input type="checkbox"/> Bridge <input type="checkbox"/> Partial <input type="checkbox"/> Denture <input type="checkbox"/> Implants
4. Person to contact for emergency: _____ Phone: _____	

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MEDICAL HISTORY

1. How do you feel about getting and maintaining a healthy mouth? _____
2. How do you feel about the appearance of your teeth? _____
3. If you could change anything about your smile, what would you change? _____
4. Are you having dental problems at this time?.....Yes No
5. Do your gums bleed at any time?.....Yes No
6. Do you feel very nervous about having dental treatment?.....Yes No
7. Have you ever had a bad experience in the dental office?.....Yes No
8. Have you been under the care of a medical doctor during the past two years?.....Yes No
If yes: for what reason? _____
Please provide the name, address, and telephone number of your physician. _____
9. Have you been a patient in the hospital during the past two years?.....Yes No
If yes: for what reason? _____
10. Have you taken any medicine or drugs during the past two years? If yes, please list:.....Yes No
11. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? If yes, please list:.....Yes No
12. Have you ever had excessive bleeding requiring special treatment?.....Yes No
13. Do you use any tobacco products?.....Yes No
14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?.....Yes No
15. Do your ankles swell during the day?.....Yes No
16. Have you lost or gained more than 10 pounds in the last year?.....Yes No
17. Do you use more than 2 pillows to sleep?.....Yes No
18. Do you ever wake up from sleep short of breath?.....Yes No
19. Are you on a special diet?.....Yes No
20. Check any of the following which apply in either past or present:

<input type="checkbox"/> Heart Valve Prolapse <input type="checkbox"/> Heart Failure <input type="checkbox"/> Heart Disease or Attack <input type="checkbox"/> Family History of Cardiovascular Disease <input type="checkbox"/> Angina Pectoris (chest pain) <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Congenital Heart Lesions <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Heart Pacemaker <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Artificial Joint of Any Type <input type="checkbox"/> Diet Medication: Name _____ <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Hemophilia <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Anemia <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Hay Fever <input type="checkbox"/> Allergies or Hives <input type="checkbox"/> Fainting or Dizzy Spells <input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> Nervousness <input type="checkbox"/> Psychiatric Treatment <input type="checkbox"/> Any Form of Eating Disorder <input type="checkbox"/> Recreational Drug Use <input type="checkbox"/> Drug Addiction/Alcoholism <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Any Form of Hepatitis <input type="checkbox"/> Liver Disease <input type="checkbox"/> Rheumatism	<input type="checkbox"/> Cortisone Medication <input type="checkbox"/> Arthritis <input type="checkbox"/> Pain in Jaw Joints <input type="checkbox"/> X-Ray or Cobalt Treatment <input type="checkbox"/> Cancer or Tumors <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> HIV Positive (AIDS) <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Cold Sores or Fever Blisters <input type="checkbox"/> Genital Herpes <input type="checkbox"/> Kidney Trouble <input type="checkbox"/> Diabetes <input type="checkbox"/> Ulcers <input type="checkbox"/> Stroke <input type="checkbox"/> Birth Control Medication <input type="checkbox"/> Pregnant – Due Date _____
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21. Do you have any disease, condition or problem not listed? If so, please list.....Yes No

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party

Relationship

Date