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

*Continued on Back >*

## 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:

❒Heart Valve Prolapse
❒ Heart Failure
❒ Heart Disease or Attack
❒ Family History of Cardiovascular Disease
❒ Angina Pectoris (chest pain)
❒ Rheumatic Fever
❒ Congenital Heart Lesions
❒ Scarlet Fever
❒ Artificial Heart Valve
❒ Heart Pacemaker
❒ Heart Surgery
❒ Artificial Joint of Any Type
❒ Diet Medication: Name_____
❒ Heart Murmur
❒ Bruise Easily
❒ Blood Transfusion
❒ Hemophilia
❒ Sickle Cell Disease

❒ High Blood Pressure
❒ Anemia
❒ Asthma
❒ Emphysema
❒ Shortness of Breath
❒ Hay Fever
❒ Allergies or Hives
❒ Fainting or Dizzy Spells
❒ Epilepsy or Seizures
❒ Nervousness
❒ Psychiatric Treatment
❒ Any Form of Eating Disorder
❒ Recreational Drug Use
❒ Drug Addiction/Alcoholism
❒ Tuberculosis (TB)
❒ Any Form of Hepatitis
❒ Liver Disease
❒ Rheumatism

❒ Cortisone Medication
❒ Arthritis
❒ Pain in Jaw Joints
❒ X-Ray or Cobalt Treatment
❒ Cancer or Tumors
❒ Chemotherapy (Cancer, Leukemia)
❒ Thyroid Disease
❒ Glaucoma
❒ HIV Positive (AIDS)
❒ Venereal Disease
❒ Cold Sores or Fever Blisters
❒ Genital Herpes
❒ Kidney Trouble
❒ Diabetes
❒ Ulcers
❒ Stroke
❒ Birth Control Medication
❒ Pregnant – Due Date_____

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