We are pleased to Welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date________________________ SS#/ID______________________________________

Patient ____ Nickname ________________________
Last Name First Name Middle Initial

Address ____
Street City State Zip

Home phone ( )________________ Work phone ( )________________ Cell phone ( )________________

Sex M___ F___ Age_________ Birthdate______________ □ Single □ Married □ Divorced □ Widowed

Person Financially responsible ____
Last Name First Name Relationship to Patient

Address____
Street City State Zip

Home phone ( )________________ Work phone ( )________________ Cell phone ( )________________

In case of an Emergency, contact (Specify someone who does not live in your household)

Name ____ Relationship________________________________

Daytime phone ( )________________________________ (Best phone number where person can be reached easily)

Employment

Occupation____ Employer________________________________

Employer Address__________________________________ Employer Phone ( ) ________________________

Spouse's Name____________________________________ Birthdate____________ SS#________________

Occupation____ Employer________________________________

Whom may we thank for referring you? ____

Insurance

Subscriber____ Birthdate_____________ SS#/ID______________
Last name First Name Initial

Insurance Co. _____________________________________ Group# ______________________________

Is patient covered by additional dental insurance? □ **Yes** □ **No**

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________________ and assign directly to Caparelli and Mellis, DDS, PLLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I also understand that I am responsible for knowing what is covered and what Is excluded from my dental plan. ______________** (Initial)

Signature____ Relationship to Patient___________________________

Dental History

Reason for today's visit___________________________________ Former Dentist____
Last dental visit____ City/State____
Reason for last dental visit_______________________________ How often do you floss?________________________________
Date of last dental x-rays________________________________ How often do you brush?________________________________

Place a mark on yes or no to indicate if you have had any of the following:

Condition		Condition		Condition	
Bad Breath	☐ yes ☐ no	Jaw pain or tiredness	☐ yes ☐ no	Sensitivity when biting	☐ yes ☐ no
Bleeding gums	☐ yes ☐ no	Lip or cheek biting	☐ yes ☐ no	Sores or growths in mouth	☐ yes ☐ no
Blisters on lips or mouth	☐ yes ☐ no	Loose teeth or broken fillings	☐ yes ☐ no	Smoking (cigarette, pipe or cigar)	☐ yes ☐ no
Burning sensation on tongue	☐ yes ☐ no	Mouth breathing	☐ yes ☐ no	Tobacco use	☐ yes ☐ no
Clicking or popping jaw	☐ yes ☐ no	Mouth pain, brushing	☐ yes ☐ no		
Dry mouth	☐ yes ☐ no	Orthodontic treatment	☐ yes ☐ no		
Food collection between teeth	☐ yes ☐ no	Pain around ear	☐ yes ☐ no		
Grinding teeth	☐ yes ☐ no	Sensitivity to cold	☐ yes ☐ no		
Gums swollen or tender	☐ yes ☐ no	Sensitivity to heat	☐ yes ☐ no		
		Sensitivity to sweets	☐ yes ☐ no		

Health History

Have you ever taken any bisphosphonate drugs including, but not limited to Fosamax, Actonel, Aredia and Zometa? ☐ yes ☐ no

Place a mark on yes or no to indicate if you have had any of the following:

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Emphysema	☐	☐	Liver Disease
☐	☐	Alcohol Abuse	☐	☐	Epilepsy	☐	☐	Low Blood Pressure
☐	☐	Allergies	☐	☐	Fainting Spells	☐	☐	Mitral Valve Prolapse
☐	☐	Anemia	☐	☐	Fever Blisters	☐	☐	Pace Maker
☐	☐	Angina Pectoris	☐	☐	Frequent Headaches	☐	☐	Pneumocystitis
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Psychiatric Problems
☐	☐	Artificial Bones	☐	☐	Hay Fever	☐	☐	Radiation Therapy
☐	☐	Artificial Heart/Valve	☐	☐	Heat Attack	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Hear t Murmur	☐	☐	Seizures
☐	☐	Blood transfusion	☐	☐	Heart Surgery	☐	☐	Shingles
☐	☐	Cancer-Chemotherapy	☐	☐	Hemophilia	☐	☐	Sickle Cell Anemia
☐	☐	Colitis	☐	☐	Hepatitis A	☐	☐	Sinus Problems
☐	☐	Congenital Heart Defect	☐	☐	Hepatitis B	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Thyroid Problems
☐	☐	Difficulty Breathing	☐	☐	Hiv + AIDS	☐	☐	Tuberculosis
☐	☐	Drug Abuse	☐	☐	Kidney Problems	☐	☐	Ulcers
						☐	☐	Venereal Disease
						☐	☐	Yellow Jaundice

Females: Are you pregnant? ☐ Yes ☐ No # of weeks__________________
Taking birth control pills? ☐ Yes ☐No
Are you nursing? ☐Yes ☐No

Do you wear contact lenses? ☐ Yes ☐ No

Are there any other medical conditions you have that are not listed? ☐No ☐Yes ____

Medications

List any medications you are currently taking and the correlating diagnosis:____
____
____
____
( ) I am not taking any medications (please check if applicable)

Allergies

☐ Aspirin	☐ Metals
☐ Codeine	☐ Penicillin
☐ Dental Anesthetic	☐ Sulfa
☐ Erythromycin	☐ Tetracycline
☐ Jewelry	☐ Other ______________
☐ Latex	☐ None