Get Acquanted Questionnaire

Lee Gaglione, D.D.S.
Andrew Scott, D.D.S.

In order for us to serve you, please complete the following confidential information:

PATIENT INFORMATION

PATIENT'S NAME: _____
Last First Middle

DATE OF BIRTH: _____
SOCIAL SECURITY NO. _____
MARITAL STATUS: ❑ Single ❑ Married
SEX: ❑ Male ❑ Female
TELEPHONE:
Res _____ Bus. _____
RESIDENCE ADDRESS _____
City _____ State _____ Zip _____

OCCUPATION _____
EMPLOYER _____
BUSINESS ADDRESS _____
City _____State _____ Zip_____
IF CHILD: GUARDIAN'S NAME
_____
Mother Father

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
_____

EMERGENCY INFORMATION

(NAME OF RELATIVE NOT LIVING WITH YOU)

NAME: _____
Last First Middle
ADDRESS _____
City _____ State _____ Zip _____

TELEPHONE:
Res _____ Bus. _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____
Last First Middle

RELATIONSHIP _____
ADDRESS _____
City _____ State _____ Zip _____
OCCUPATION _____
EMPLOYER _____
METHOD OF PAYMENT: ❑ Cash ❑ Check ❑ Credit Card

We are committed to providing you with optimum oral health care in a timely and professional manner. For your benefit a thorough examination, including appropriate diagnostic measures, are necessary before an intelligent and efficient analysis of your dental problems can be made.

After a comprehensive diagnosis, your dental problems can be discussed; treatment can be planned, and your investment in dental health understood and arranged.

The information on this page and the health history are correct to the best of my knowledge. I will notify Dr. Gaglione of any change in my heath or medication.

I hereby authorize Lee Gaglione D.D.S. Andrew Scott D.D.S. to furnish information to insurance carriers concerning my dental condition and treatments. I hereby assign to the doctor all payments for dental services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. Patients copay and estimated share will be due at time of service. In the event my account should become delinquent for a period of 60 days or more, I acknowledge that I will be responsible for all of the balance, interest, court cost and/or attorney fees involved with collecting on my account.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ **DATE** _____

DENTAL INSURANCE

Employee Name _____ Date of Birth _____ Identification No. _____
Employer _____ # years _____
Name of Insurance Co. _____
Address _____ Telephone _____
Program or Policy # _____
Union Local or Group _____
Do you have additional Dental Insurance? _____
The filing of insurance claims is a courtesy that we extend to our patients. We must emphasize that as dental care providers, our relationship is with you, not your insurance company.

PLEASE complete Health History on the other side

TODAY'S DATE _____

HEALTH HISTORY

How would you describe your general health? _____

Are you allergic to any medications or materials? _____

(Penicillin, Codeine, Nickel, Latex Rubber, etc.)

Has any allergic reaction resulted in hives, hayfever, asthma, etc.? _____

Do you smoke or chew tobacco? _____

PHYSICIAN'S NAME _____ **DATE OF LAST PHYSICAL** _____

Are you currently under a physician's care? _____

Have you ever had any operations? _____

Please list all the drugs you are taking (including over-the-counter medications) _____

_____

DO YOU NOW HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE & MARK YES OR NO IN THE SPACE PROVIDED)

	YES	NO
HEART DISEASE (Abnormal Blood Pressure, Heart Murmur, Rheumatic Fever, Heart Valve Replacement, Mitral Valve Prolapse, Pacemaker, Bypass Surgery) _____	❑	❑
ARTIFICIAL JOINTS OR PROSTHESES _____	❑	❑
LIVER DISEASE (Hepatitis) _____	❑	❑
DIABETES _____ **IF SO, ARE YOU TAKING INSULIN?** _____	❑	❑
STROKE _____	❑	❑
EPILEPSY OR SEIZURES _____	❑	❑
PSYCHIATRIC CARE _____	❑	❑
KIDNEY TROUBLE _____	❑	❑
LUNG DISEASE (Asthma, Tuberculosis, Emphysema) _____	❑	❑
DIGESTIVE TRACT DISORDER (Ulcers) _____	❑	❑
BLOOD DISORDERS (Prolonged Bleeding, Hemophilia, Anemia) _____	❑	❑
CANCER (Chemotherapy, Radiation Therapy) _____	❑	❑
IMMUNE DEFICIENCY (HIV, Arthritis, Cold Sores) _____	❑	❑
VENEREAL DISEASE (Herpes) _____	❑	❑
HAVE YOU EVER HAD ANY OTHER SERIOUS ILLNESS? _____	❑	❑
For **WOMEN** only:	❑	❑
Are you taking birth control medication or any hormone therapy? _____	❑	❑
Are you pregnant? _____	❑	❑
Are you nursing? _____	❑	❑

PREVIOUS DENTIST'S NAME _____ **DATE OF LAST VISIT** _____

Do you have any pain in your teeth because of hot, cold, or sweets? _____	❑	❑
Do you have any pain in any part of your mouth while biting or chewing?_____	❑	❑
Do your gums feel irritated, tender, swollen, or bleed while brushing? _____	❑	❑
Do you know of any growths, unhealed injuries or sore spots in your mouth? _____	❑	❑
Do you chew on both sides of your mouth? If no, why not? _____	❑	❑
Do you ever have a ringing sensation or pain in your ears? _____	❑	❑
Is any part of your mouth sore to clinching or grinding your teeth? _____	❑	❑
Have you ever had:		
Any unusual or allergic symptoms to local anesthetic? _____	❑	❑
Any difficult extractions in the past? _____	❑	❑
Prolonged bleeding following extractions in the past? _____	❑	❑

When was your last full mouth x-ray taken? _____ Where? _____

Do you have any present dental complaints? _____

_____

MEDICAL HISTORY UPDATE

Date: _____	Date: _____	Date: _____	Date: _____
_____	_____	_____	_____
_____	_____	_____	_____