York J. Fitzgerald, DDS
Family and Cosmetic Dentistry

PATIENT INFORMATION

Name _____ DOB ____/____/_____ Age_____ Date _____
Last First Middle
Address_____City _____ Zip_____
Home ( )_____ Work ( )_____ Cell ( ) _____ e-mail_____

Patient's Social Security Number _____ Drivers Lic.# _____ Expires_____
Patient's Occupation _____ Employer (or College) _____
Employer's (or College's if student) Address_____
Marital Status _____ Spouse's Name _____ If minor, parents or guardians _____
Person responsible for account _____ Relationship to patient _____ Drivers License # _____
Name of relative not living with you _____ Relationship to patient _____
Address _____ Phone (____) _____
Physician _____ Address _____ Phone (____) _____
Former Dentist _____ Address _____ Phone (____) _____
How did you hear about our office? _____

INSURANCE INFORMATION Do you have Dental Insurance? Yes No

Primary Insurance:
Employed Person's Name _____ Date of Birth _____Social Security # _____
Employer _____ Name of Insurance _____
Insurance Mailing Address_____
Relationship of employed to patient _____ Group or Local # _____

Secondary Insurance:
Employed Person's Name _____ Date of Birth _____Social Security # _____
Employer _____ Name of Insurance _____
Insurance Mailing Address_____
Relationship of employed to patient _____ Group or Local # _____

HEALTH INFORMATION *Please answer each question for the patient.* *Please mark appropriate answer.*

	YES	NO
1. Are you in good health?	❑	❑
2. Have you been treated by a physician in the past two years?	❑	❑
If yes, for what? _____		
3. Have you had any serious illness, operations, or been hospitalized in past 3 years?	❑	❑
If yes, please explain _____		
4. Are you currently taking any drugs or medicines? (including aspirin, pain pills or non-prescription drugs)	❑	❑
If yes, what? _____		
5. Have you had any type of heart surgery?	❑	❑
If yes, please explain _____		
6. Do you have artificial heart valves?	❑	❑
7. Do you have a history of infective endocarditis?	❑	❑
8. Do you have any serious congenital heart conditions?	❑	❑
9. Do you have a cardiac transplant that has developed a problem with the heart valves?	❑	❑
10. Have you had a blood transfusion since 1975?	❑	❑
If yes, when? _____		
11. (Women) Are you pregnant?	❑	❑
Do you take birth control pills?	❑	❑

If yes, please be advised that antibiotics which may be given to you for oral infections may render your birth control pills ineffective. Therefore another form of birth control must be used for the duration of the menstrual cycle during which you take the antibiotic.

PLEASE CONTINUE > > > > > > > > > > > > > > >

	YES	NO
12. Are you sensitive or allergic to any drugs? (Penicillin, Tetracycline, Sulfa, Erythromycin, Novocain, Codeine, etc.)	❑	❑
If yes, what? _____		
What type of reaction do you have? _____		
13. Do you have allergies to any metals or other substances? (including nickel, latex, clove oil, etc.)	❑	❑
If yes, what? _____		
14. Have ever taken any medications for osteoporosis? (such as Fosamax,Boniva,Actonel,Reclast, Didronel)	❑	❑
If yes, what, when and how long? _____		

HEALTH HISTORY — Do you have, or have you had any of the following? — Please check if applicable.

❑ Anemia	❑ Head or Neck Radiation Treatment	❑ Rheumatic Heart Disease
❑ Asthma	❑ Hepatitis, Liver Disease	❑ Rheumatism/Arthritis
❑ Cancer or Tumors	❑ High Blood Pressure	❑ Sinus Pain
❑ Chest Pain or Angina	❑ HIV-AIDS	❑ Stroke
❑ Diabetes	❑ Kidney Disease	❑ Surgically Placed Heart Valves
❑ Epilepsy/Convulsions	❑ Nervous Disorders	❑ Tuberculosis
❑ Excessive Bleeding	❑ Respiratory Disease	❑ Phen-Fen related heart problems
❑ Glaucoma	❑ Rheumatic Fever	❑ Osteoporosis

Do you have any disease, condition, or problem not listed above that you think I should know about?	YES	NO
If yes, what? _____	❑	❑

DENTAL INFORMATION — Please check appropriate answer.

	YES	NO
1. When did you last have a cleaning/checkup? _____		
2. When did you last have x-rays taken? _____		
3. Have you ever been treated for periodontal disease (gum disease)?	❑	❑
If yes, when, by whom, what was treatment? _____		
_____		
4. How often do you have your teeth professionally cleaned? _____		
5. Do your gums bleed when you brush or floss?	❑	❑
6. Do you drink or cook with bottled water?	❑	❑
If yes, is your bottled water fluoridated or do you take fluoride supplements? _____		
7. Have you had any complications from an extraction? (Such as excessive bleeding?)	❑	❑
If yes, please explain _____		
8. Have you ever had an unusual or unpleasant experience in the dental office (including not getting numb) ?	❑	❑
If yes, please explain _____		
9. Do you have any areas of your mouth that are bothering you now?	❑	❑
If yes, please explain _____		

CONSENT

I hereby authorize and request the doctor(s) to perform necessary x-rays, photographs, prophylactic and surgical procedures for the treatment and/or prevention of oral disease and do whatever treatment that his/her judgment may dictate. I also authorize and request the administration of such medications, anesthesia, or anesthetics as may be deemed advisable by the doctor(s) after they have been explained to me so that my consent is informed. I will inform my dentist of any changes in my health and/or medication. Further, I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I authorized the dentist to contact my physician(s) if medical consultation is necessary.

I authorize release of any information relating to my dental claim. I understand that I am responsible for all costs of any treatment. I authorize payment directly to the doctor(s) of the group insurance benefits otherwise payable to me.

I certify that the above history was carefully considered and complete information was given.

X_____ _____ _____ _____

Patient Signature (Or parent/guardian if patient is a minor) Date Reviewed By Date

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