WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

LVI Preferred Dentist

Vincent A. Grosso II, D.M.D.

About You

Today's Date: _____ E-mail Address: _____

Name: _____ Name I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Home Phone #: (_____)_____ Cell #: (_____)_____ Work Phone #: (_____)_____ Ext: ____ DL #: _____

Best phone # to confirm appointment? _____ Whom may we thank for referring you? _____

Did you hear of us from? ❑ Web Site ❑ TV Commercial ❑ Hunters Creek Magazine ❑ Other: _____

Other family members seen by us: _____

Employer: _____ Occupation: _____

Emergency Contact Information

His / Her Name: _____ Birthdate: ___/___/___ Relationship: _____

Home Phone #: (_____)_____ Work Phone #: (_____)_____ Ext: _____

Insurance Information

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Insured's Birthdate: ____/____/____

Insured's Address: _____
Street City State Zip

Insured's Social Security #: _____ Insured's ID #: _____

Relationship: _____ Insured's Employer: _____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of toothbrush? ❑ Manual ❑ Battery ❑ Electric

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? ❑ Yes ❑ No

Previous Dentist: _____ Last Visit Date: _____

Why did you leave your last dentist? _____

CONTINUED ON BACK

Dental History (continued)

Are you satisfied with the appearance of your teeth? ❑ Yes ❑ No

If No, what would you like to change: *(circle those that apply)*
Length, Shade, Spaces, Crowding, Other:_____

_____

Have you ever had any serious complications with prior dental treatment? ❑ Yes ❑ No
If yes, what ? _____

Have you had any head, neck or jaw injuries? ❑ Yes ❑ No

Do you have frequent headaches? ❑ Yes ❑ No

Have you ever experienced any of the following problems in your jaw?

Clicking? ❑ Yes ❑ No

Pain (joint, ear, side of face)? ❑ Yes ❑ No

Difficulty in opening or closing? ❑ Yes ❑ No

Difficulty in chewing? ❑ Yes ❑ No

Do you clench or grind your teeth? ❑ Yes ❑ No

Have you had any orthodontic work? ❑ Yes ❑ No

Have you ever whitened your teeth? ❑ Yes ❑ No
If yes, what type of product? _____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever taken Fosamax or any other Bisphosphonate? ❑ Yes ❑ No

Have you ever taken Phen-Fen, Redux or Pondimin? ❑ Yes ❑ No

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription/over the counter drugs, blood thinners or heart medications? ❑ Yes ❑ No If yes, please list each one: _____

_____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have received a copy of this offices Notice of Privacy Practices.

_____
Signature Date

office use only office use only office use only office use only **Medical History Update** *office use only office use only office use only office use*

I have read my medical history dated _____ and confirmed that it states past and present medical condition _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical condition _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical condition _____
Signature Date