ATLANTIC DENTAL WELLNESS: HOLISTIC, RESTORATIVE, & SPORTS DENTISTRY

Leonard T. Fazio, D.D.S., Director

P: 631.474.7477 E: info@HolisticSmiles.com W: www.HolisticSmiles.com

1303 Main Street, Suite 2 | Port Jefferson, NY 11777

NEW PATIENT REGISTRATION AND HEALTH FORM

CONTACT INFORMATION

Patients Name_____ Date_____

Mailing Address_____ City_____ State____ Zip_____

Sex: M F Age_____ Birth Date_____ SS#_____-_____-_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email _____ (circle one) Single Married Separated Divorced

Patients Employer/School_____ Occupation_____

Employer/School Address_____ Phone _____

Referral Source: Who can we thank for referring you? _____

EMERGENCY CONTACT INFORMATION

Name_____

Relationship _____

Home Phone _____ Work Phone_____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance

Name of Responsible Party _____ DOB_____ SS#_____-____-_____

Relationship to Patient _____ Insurance Co. _____

Group#: _____

Employer_____ Address_____

SECONDARY INSURANCE (IF APPLICABLE)

Name of Responsible Party_____ DOB _____ SS#_____-____-_____

Relationship to Patient_____ Insurance Co._____

Group#_____

Employer_____ Address_____

MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT

Please list some of the problems or questions you would like to speak to the doctor about.

1._____

2._____

3._____

ADDITIONAL PROBLEMS OR CONCERNS YOU WOULD LIKE ADDRESSED

_____

_____

_____

_____

_____

DENTAL HISTORY

Date of last dental cleaning _____ Date of last dental x-rays taken_____

How often do you brush your teeth? _____ How often do you floss? _____

Do you think you have active tooth decay of gum disease? Yes No

Have you ever had gum treatment or surgery? Yes No

If yes, when? _____ And where? _____

Do your gums bleed? Yes No

Do you have any loose teeth? Yes No

Do you have clicking, popping, or discomfort in the jaw joints? Yes No

Do you grind or clench your teeth? Yes No

Do you smoke or chew tobacco? Yes No

Do you have any tongue or lip piercings? Yes No

Have you ever had or do you presently wear braces? Yes No

Do you presently wear a removable partial or denture? Yes No

Do you have sensitivity to hot? Yes No

Do you have sensitivity to cold? Yes No

Do you have sensitivity to sweets? Yes No

Do you have sores or growths in your mouth? Yes No

Do you have problems with food collection between teeth? Yes No

HEALTH HISTORY

Date of last health care exam_____ What was this exam for? _____

Have you been hospitalized in the last 5 years? Yes No

If yes, reason_____

Are you currently receiving care? Yes No

*Please list **ALL** the names and phone numbers of the physicians who are currently providing you care.*

Name _____ Name _____

Phone _____ Phone _____

Name_____ Name _____

Phone_____ Phone _____

WOMEN

Are you pregnant? Yes No – If yes, what is your due date? _____

Are you currently breast feeding? Yes No

Are you taking oral contraceptives? Yes No

Please mark yes or no to indicate if you have had any of the following.

Chest Pain	Yes No	Shortness of Breath	Yes No	Hives or Skin Rash	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease or Attack	Yes No	Developmental Disabilities	Yes No	Herpes	Yes No
When? _____					
Angina Pectoris	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting or dizzy spells	Yes No	*Steroid Treatment	Yes No
Liver Disease	Yes No	Easting disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy or Seizures	Yes No	*Any type of Implant	Yes No
				What Type? _____	
High Blood Pressure	Yes No	Persistent Cough	Yes No	Cancer	Yes No
				What Type? _____	
*Heart Murmur	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
*Rheumatic Fever	Yes No	Asthma	Yes No	HIV Positive, ARC, AIDS	Yes No
Psychiatric Treatment	Yes No	*Congenital Heart Prob.	Yes No	Hay Fever	Yes No
Sickle Cell Disease	Yes No	Hepatitis A(Infectious)	Yes No	Use of tobacco	Yes No

Sinus Trouble	Yes No	Hepatitis B(Serum)	Yes No	Bruise easily	Yes No
*Artificial Joints	Yes No	Hepatitis C or other	Yes No	Jaundice	Yes No
Thyroid Disease	Yes No	Heart Pacemaker	Yes No	Heart Surgery	Yes No
Anemia	Yes No	Stroke	Yes No	Kidney Trouble	Yes No
Blood Transfusion	Yes No	Drug Addiction	Yes No	Hemophilia	Yes No
*Any type of transplant	Yes No	Cold Sores	Yes No	Diabetes	Yes No
*Mitral Valve Prolapse	Yes No	Radiation Therapy	Yes No	Chemotherapy	Yes No

Antibiotic pre-medication may be required prior to your appointment.

Are you required to Pre-Medicate before dental treatment? Yes No

ALLERGIES

Are your ALLERGIC or have you ever experienced any reaction to the following?

Local Anesthetics(Novocain)	Yes No	Aspirin or codeine	Yes No
Barbiturates/sedatives/sleeping pills	Yes No	Sulfa drugs	Yes No
Penicillin/other antibiotics	Yes No	Others_____	

MEDICATIONS

Are you taking any of the following medications?

Antibiotics/sulfa drugs	Yes No	Tranquilizers	Yes No
Blood thinners	Yes No	Insulin/other diabetes drugs	Yes No
Blood pressure medications	Yes No	Digitalis/other heart drugs	Yes No
Thyroid medications	Yes No	Nitroglycerin	Yes No
Cortisone/steroids	Yes No	Aspirin	Yes No
Recreational drugs	Yes No	Antihistamines/allergy drugs	Yes No
Antacids	Yes No	Tagamet(Cimetidine)	Yes No

Current Medications	**Dose**	**Times/Day**
Current Herbs/Vitamins/Supplements	**Dose**	**Times/Day**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (print name) ***Patient Signature*** ***Date***

DOCTOR'S USE ONLY!

Comments on patient interview concerning medical history:

_____
_____
_____
_____
_____

Significant findings from questionnaire or oral interview:

_____
_____
_____

_____ _____ _____

Doctor (print name) ***Doctor Signature*** ***Date***