PATIENT'S HISTORY

This information is confidential and will not be released to anyone.

LEGAL NAME _____Nickname _____SS#_____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

PHONE (H) _____ (W) _____ (C) _____ Email _____

DATE OF BIRTH _____ Age _____ _____ MARRIED _____ SINGLE _____ MALE _____ FEMALE

PERSON RESPONSIBLE FOR ACCOUNT _____

SOCIAL SECURITY NUMBER _____ DRIVER'S LICENSE NUMBER _____

EMPLOYER _____ PHONE NUMBER _____

WHO REFERRED YOU TO THIS OFFICE? _____

When was your last visit to a dentist?_____

Were full mouth Xrays taken then? Y N

Have you used Nitrous Oxide or Laughing gas? Y N

Preferred filling color for back teeth: _____ White _____ Silver

Rate you smile: (dislike) 1 - 2 - 3 - 4 - 5 (love)

Would you like your teeth to be whiter? Y N

Chief dental complaint _____

Do your gums bleed or feel tender or irritated? Y N

Do you have halitosis (mouth odor)? Y N

Do you grind your teeth? Y N

Why did you leave your last dentist? _____

Has your doctor said that you need to be premedicated before dental treatments? Y N

Do you use any tobacco products? Y N

WOMEN

Are you pregnant? Y N

If yes, when are you expecting? _____

Are you taking birth control pills? Y N
(If yes, antibiotics may diminish the effect)

Do you have or have you had…

High blood pressure Y N

Heart trouble, Rheumatic fever or Heart murmur Y N

Diabetes, Asthma, Tuberculosis Y N

Kidney or Liver involvement or Hepatitis Y N

Venereal disease (Syphilis, Gonorrhea, Etc.) Y N

Immuno Suppressive Disorders (HIV, AIDS) Y N

Attention Deficit Disorder (ADD, or ADHD) Y N

Sinus trouble Y N

Fainting spells or Seizures Y N

Have you taken Bisphosphonate therapy (Arebia, Zometa, Actonel, Boniva, Fosamax, Skelif, or Didronel)? (If yes, please circle) Y N

Allergic or sensitive to: Aspirin, Penicillin, Codeine, Local anesthetic, Erythromycin, Silver, Aluminum, Mercury, Tin, Copper, Zinc, Nickel, Chrome, Beryllium, Molybdenum, Latex or any drugs (If yes, please circle) Y N

Subject to profuse bleeding? Y N

List of medications you are now taking: _____

_____

Other conditions? _____

Acknowledgment of Jayson D. Voto, DDS Family and Cosmetic Dentistry Notice of Privacy Practices (HIPPA)

The signature below only acknowledges receipt of the Jayson D. Voto, DDS Family and Cosmetic Dentistry Notice of Privacy Practices

_____ _____ _____

Print name of Patient/Representative Signature of Patient/Patient Representative Date

_____ Check here if you decline to sign _____ Staff Initials

CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aid deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I realize every attempt is made to correctly estimate co-payments; however, any unpaid balance after insurance pays is my responsibility. I also assign all insurance benefits to the Doctor. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires above have been answered to my satisfaction. I will not hold my Dentist responsible to any errors or omissions that I have made in the completion of this form. I will inform the Doctor of any change in my Health History during subsequent appointments.

Patient Signature (Parent if minor) _____ Date _____