MICHAEL VANARIA, D.M.D

WELCOME

1 ABOUT YOU

Today's Date:_____/_____/_____

Patient Name:______________________________________

LAST FIRST MI

What You Prefer To Be Called: _____________ ❑ Male ❑ Female

Birthdate: ____/____/____ Age:_____ SS#:_____________

Mailing Address: ______________________________________

CITY STATE ZIP

Home Phone # : ______________________________________

Work Phone # : ______________________________________

Mobile Phone # : ______________________________________

E-mail Address : ______________________________________

Referred By: ______________________________________

Employer: ______________________ How Long?_________

Employer's Address: ______________________________________

CITY STATE ZIP

Occupation:______________________________________

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name:______________________________________

Do you have children? ❑ Yes ❑ No How many:__________

2 INSURANCE INFO

Primary Dental Insurance

Co. Name:______________________________________

Address: ______________________________________

CITY STATE ZIP

Phone #: ______________________________________

Insured's SS#: ______________________________________

Insured's ID#:______________________________________

Group # (Plan, Local, or Policy #): ____________________

Insured's Name:______________________________________

Relation:_____________ Date of Birth:____/____/____

Insured's Employer:______________________________________

Secondary Dental Insurance

Co. Name:______________________________________

Address: ______________________________________

CITY STATE ZIP

Phone #: ______________________________________

Insured's SS#: ______________________________________

Insured's ID#:______________________________________

Group # (Plan, Local, or Policy #): ____________________

Insured's Name:______________________________________

Relation:_____________ Date of Birth:____/____/____

Insured's Employer:______________________________________

3 ACCOUNT INFO

Person ultimately responsible for account

Name:______________________________________

Relation: ______________________________________

Billing Address: ______________________________________

CITY STATE ZIP

SS #: ______________________________________

Driver's License #: ______________________________________

Work Phone #: ______________________________________

4 IN EVENT OF EMERGENCY

Who should we contact?: ______________________________________

Relation: ______________________________________

Home Phone#: ______________________________________

Work Phone #: ______________________________________

5 DENTAL INFORMATION

Reason for today's visit: ____________________

Are you in pain? ❑ No ❑ Yes ❑ How long? ____________________

Please indicate ☑ any of the following problems:

- ❑ Discomfort, clicking or popping in jaw.
- ❑ Lost/Broken Fillings
- ❑ Stained teeth
- ❑ Broken/Chipped tooth
- ❑ Red, swollen or bleeding gums
- ❑ Teeth grinding
- ❑ Locking Jaw
- ❑ Bad breath
- ❑ Sensitive tooth, teeth or gums
- ❑ Ringing in Ears
- ❑ Blisters/Sores in or around the mouth
- ❑ Other: ____________________

Do you require the use of antibiotics prior to dental visit? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ____________________ ( ) ____________________
Name — Phone Number

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day you brush? ____________ Times a week you floss? ____________

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6 MEDICAL HISTORY

Do you have or have you had any of the following diseases, medical conditions or procedures?

- ❑ Heart Attack/Stroke
- ❑ Heart Surg./Pacemaker
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Mitral Valve Prolapse
- ❑ Artificial Valves
- ❑ Heart Disease
- ❑ Congenital Heart Defect
- ❑ Chest Pains
- ❑ Scarlet Fever
- ❑ Nervousness
- ❑ Autism
- ❑ Thyroid Problems
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Respiratory Problems
- ❑ Sinus Problems
- ❑ Stomach Problems/Ulcers
- ❑ Psychiatric Problems
- ❑ Venereal Disease
- ❑ Alcohol/Drug Abuse
- ❑ Tuberculosis TB
- ❑ Jaw Problems TMJ/TMD
- ❑ ADHD
- ❑ Cancer/Tumors
- ❑ Shingles
- ❑ Hepatitis
- ❑ HIV+/AIDS/ARC
- ❑ Arthritis/Rheumatism
- ❑ Artificial Bones/Joints
- ❑ Emphysema
- ❑ Fainting/Seizures/Epilepsy
- ❑ Severe/Frequent Headaches
- ❑ Frequent Neck Pain
- ❑ Back Problems
- ❑ Depression
- ❑ Cosmetic Surgery
- ❑ Radiation Treatment
- ❑ Chemotheraphy
- ❑ Asthma
- ❑ Difficulty Breathing
- ❑ Diabetes/Hypoglycemia
- ❑ Leukemia
- ❑ Anemia
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Bleeding Problems
- ❑ Glaucoma

Please list any other medical condition(s) you have or ever had: ____________________

____

____

Please list all medications you are taking: ____________________

____

Pharmacy Name and Phone# ____________________

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Dental Anesthetics ❑ Others: ____________________

Do you use tobacco? ❑ No ❑ Yes/How used? ____________ How much? ________ How long? ________

Please rate your general health from 1-10: ____________ Do you wear contact lenses? ❑ Yes ❑ No

Have you ever taken the drug Phen-fen and or Redux? ❑ Yes ❑ No How many children have **you** had?

Are you pregnant? ❑ No ❑ Yes/How long? ________ Are you nursing? ❑ Yes ❑ No

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- ➤ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- ➤ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsibile for the legal fees collection agency fees, interest charges any other expenses incurred in collecting your account.
- ➤ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ➤ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I have provide.
- ➤ I understand this office requires a 24 hour cancellation notice. If I do not cancel prior to the 24 hour, I may incur a $50.00 charge

Signature ____________________ Date ____/____/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

Initials	Date
________	___/___/___
________	___/___/___
________	___/___/___