LADONE FAMILY DENTAL CENTER

Patient Information

(Please Print) Date _____

Name _____ SS# _____
First MI Last

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____

Cell # _____ Birthdate _____

E-mail Address _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to us? _____

Responsible Party

(IF NOT THE SAME AS ABOVE)

Name of person responsible for this account _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work # _____

Insurance Information

Name of Insured_____ Relationship to patient _____

Birthdate _____ SS# _____ Work phone # _____

Name of Employer _____ Address _____

Insurance Co. _____ Group _____

Insurance Co. Address _____ City _____ State _____ Zip _____

OVER PLEASE

Paul J. Ladone, D.D.S.

Dental History

Reason for today's visit _____ Date of last exam _____
Date of last dental X-rays _____ How often do you brush _____ How often do you floss _____

Do any of the following conditions apply to you? Please select Y or N:

Y N Desire for whiter teeth	**Y N Loose teeth or broken fillings**	**Y N Sensitivity when biting**
Y N Improved appearance	**Y N Bleeding gums**	**Y N Sores or growths in mouth**
Y N Grinding teeth	**Y N Gum treatment**	**Y N Sensitivity to sweets**
Y N Clicking or popping jaw	**Y N Sensitivity to cold**	**Y N Bad breath**
Y N Food collection between teeth	**Y N Sensitivity to hot**	**Y N Do you participate in any sport?**

Specify _____

Medical History

Physician _____ Date of last visit _____

Please list all medications you are currently taking _____

_____

Are you allergic or have you reacted to any of the following? Please select Y or N:

Y N Local Anesthetics	**Y N** Penicillin	**Y N** Codeine	**Y N** Erythromycin	**Y N** Metal
Y N Aspirin	**Y N** Tetracycline	**Y N** Latex	**Y N** Sulfa drugs	Other _____

Do you have a history of the following? Please select Y or N:

Y N AIDS	**Y N** Epilepsy	**Y N** HIV positive	**Y N** Shortness of breath
Y N Allergies	**Y N** Fainting	**Y N** Jaw pain	**Y N** Swelling of feet or ankles
Y N Anemia	**Y N** Glaucoma	**Y N** Kidney disease	**Y N** Thyroid problems
Y N Arthritis, rheumatism	**Y N** Headaches	**Y N** Liver disease	**Y N** Tobacco habit
Y N Artificial heart valves	**Y N** Heart murmur	**Y N** Mitral valve prolapse	**Y N** Tonsillitis
Y N Artificial joint	**Y N** Heart problems	**Y N** Nervous problems	**Y N** Tuberculosis
Y N Asthma	Describe _____	**Y N** Pacemaker	**Y N** Ulcer
Y N Cancer	_____	**Y N** Radiation treatment	**Y N** Venereal disease
Y N Chemotherapy	_____	**Y N** Respiratory disease	**Y N** Osteoporosis
Y N Cortisone Treatments	**Y N** Hepatitis	**Y N** Sinus problems	**Y N** Bisphonates(BoneMeds)
Y N Diabetes	**Y N** High blood pressure	**Y N** Rheumatic fever	Other _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
SIGNATURE OF PATIENT (or parent, if a minor) **DATE**