Welcome to Our Practice!

Patient First Name M.I. Last Name SSN Birthdate

Spouse's Name SSN Birthdate

Address

City State ZIP

Home Phone # ( ) Work Phone # ( )

Cell Phone # ( ) Spouse's Cell Phone # ( )

e-mail(s) Patient's Employer(s)

Which phone number may we contact you during the day? ❑ Home ❑ Cell ❑ Work (check applicable box)

Patient Diagnostic Information

Who referred you to Dr. Codelli? ❑ Dr.: ❑ self

❑ other patient: ❑ insurance plan

In your own words, why does your dentist or you feel you need to see Dr. Codelli?

Based on what your dentist has told you and what you know about your mouth, please rate the condition of your mouth on a scale of 1 to 10 where 1 is severe disease and 10 is optimal health. (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Are you in DISCOMFORT right now? ❑ YES ❑ NO If yes, does the pain keep you awake at night? ❑ YES ❑ NO

What is your PHYSICIAN's name, telephone number, and office location (city/state)?

Physician's First Name: Last Name: Office #: ( ) City: State:

Name & Number of Person To Be Contacted in Case of Emergency, Other Than Spouse

Phone: ( )

When was the date of your LAST DENTAL CLEANING?

When was the date of your LAST FULL MOUTH X-RAYS (20 or more films)?

Have you had any type of PREVIOUS periodontal/gum therapy (including SCALING/DEEP CLEANING)? ❑ YES ❑ NO

If yes, when and where was periodontal treatment completed?

Important! Please fill out and sign the back side of this form.
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Dental Insurance

Primary Dental Insurance Information			Secondary Dental Insurance Information		
			Complete Spouse Section ***Only*** If There Is Secondary Insurance		
			Spouse's Employer		
Name of Insurance			Name of Insurance		
Address			Address		
City	State	Zip	City	State	Zip
Phone ( )			Phone ( )		
Group #	Subscriber #		Group #	Subscriber #	

Statement and Consent to Financial Arrangements

1. **Responsibility for payment for professional services provided in this office are due and payable at the time services are rendered unless prior financial arrangements have been made.**
2. **As a courtesy to patients, the business staff will assist in ascertaining insurance benefits (predetermination of benefits).**
3. **Responsibility for payment for professional services provided in this office are due and payable if for any reason insurance benefits are not made available.**
4. **It is the patient's (or guarantor's) responsibility to inform the office of any changes in insurance coverage.**
5. **A fee will be charged for filing any additional insurance other than primary.**
6. **A nominal fee will be assessed if 24-hour advance cancellation notice for appointments is not given.**
7. **A 1.5% monthly interest fee will be charged on balances over 30 days due (18% A.P.R.).**
8. **I authorize the release of all necessary information and I authorize payment of benefits directly to the provider.**

Signature of Patient or Guarantor of Account: **Date:**

For Your Information…

1. **Dental insurance is not meant to be a "PAY-ALL;" it is meant to be an aid.**
2. **The amount your plan pays is determined by the contribution you and your employer make to your dental plan.**
3. **It has been the experience of many dentists that insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying that "our benefits are too low." Remember you get back only what you and your employer put into your insurance coverage less the profits of the insurance company.**
4. **Each plan utilized in our office has different percentages, deductible, maximums, procedures covered, and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.**
5. **We make our recommendations for your well-being based on your dental needs and not on what your insurance may or may not cover.**

Important! SCROLL DOWN TO 3rd PAGE

Gregg R. Codelli, D.D.S., P.C. - Medical History

Question		
Are you in good health?	❑ YES	❑ NO
Has there been any change in your general health within the year?	❑ YES	❑ NO
When was the date of your last physical examination?		
Are you now under a physician's care?	❑ YES	❑ NO
If yes, for what condition?		
Have you had any serious illness or operation?	❑ YES	❑ NO
Have you been hospitalized or had a serious illness within the past 5 years?	❑ YES	❑ NO
Have you had any history of tumours, malignancies, or treatment for cancer of any nature?	❑ YES	❑ NO
Do you ever have pain in your chest upon exertion?	❑ YES	❑ NO
Are you ever short of breath after mild exertion?	❑ YES	❑ NO
Do you require extra pillows when you sleep or do you get short of breath when you lie down?	❑ YES	❑ NO
Do your ankles swell?	❑ YES	❑ NO
Do you have a cardiac pacemaker?	❑ YES	❑ NO
Are you thirsty much of the time?	❑ YES	❑ NO
Have you had abnormal bleeding associated with previous surgery (any type), extraction or trauma?	❑ YES	❑ NO
If yes, when and where?		
Have you ever received a blood transfusion?	❑ YES	❑ NO
Have you ever taken any of the following medications? If yes, choose which:	❑ YES	❑ NO

❑ Boniva (ibandronate sodium) ❑ Actonel (risedronate sodium) ❑ Reclast (zoledronic acid)
❑ Zometa (zoledronic acid) ❑ Aredia (pamidronate disodium) ❑ Fosamax (alendronate sodium)

ARE YOU ALLERGIC TO, OR HAVE YOU REACTED ADVERSELY TO (check or provide details):

❑ Local anesthetic(s)	❑ Epinephrine	❑ Latex	❑ Iodine/Shellfish	
❑ Penicillin	❑ Amoxicillin	❑ Tetracycline	❑ Erythromycin	❑ Other Antibiotics
❑ Aspirin	❑ Advil	❑ Aleve	❑ Other NSAIDs	
❑ Codeine	❑ Morphine	❑ Demerol	❑ Other narcotic analgesics	
❑ Versed	❑ Valium	❑ Scopolamine	❑ Barbiturates	❑ Other sedatives or sleeping pills

Please list any additional allergies not represented above:

WOMEN ONLY

Question		
Are you pregnant (answer yes if not sure)?	❑ YES	❑ NO
Are you nursing?	❑ YES	❑ NO
Are you taking birth control pills?	❑ YES	❑ NO
Do you anticipate becoming pregnant?	❑ YES	❑ NO

Do you currently or have you had:

Condition			Condition		
Heart disease/heart attack/MI	❑ YES	❑ NO	Hiatal hernia	❑ YES	❑ NO
Coronary bypass grafts	❑ YES	❑ NO	Pollen/food allergies	❑ YES	❑ NO
Hypertension/high blood pressure	❑ YES	❑ NO	Sinus trouble	❑ YES	❑ NO
High cholesterol	❑ YES	❑ NO	Osteoarthritis	❑ YES	❑ NO
Congestive heart failure	❑ YES	❑ NO	Osteoporosis/osteopenia	❑ YES	❑ NO
Angina (chest pain)	❑ YES	❑ NO	Asthma	❑ YES	❑ NO
Rheumatic fever	❑ YES	❑ NO	Hepatitis ❑ A ❑ B ❑ C	❑ YES	❑ NO
Bruise easily	❑ YES	❑ NO	Jaundice	❑ YES	❑ NO
Artificial heart valve	❑ YES	❑ NO	Liver disease	❑ YES	❑ NO
Congenital heart condition	❑ YES	❑ NO	Tuberculosis	❑ YES	❑ NO
Mitral valve prolapse	❑ YES	❑ NO	Drug addiction	❑ YES	❑ NO
Heart murmur	❑ YES	❑ NO	Alcoholism	❑ YES	❑ NO
Artificial joint in place	❑ YES	❑ NO	Hemodialysis	❑ YES	❑ NO
Stroke (CVA) or TIA's	❑ YES	❑ NO	Hemophilia	❑ YES	❑ NO
Emphysema/COPD	❑ YES	❑ NO	Glaucoma	❑ YES	❑ NO
Diabetes (Type 1, insulin dependent)	❑ YES	❑ NO	HIV/AIDS	❑ YES	❑ NO
Diabetes (Type 2, no insulin)	❑ YES	❑ NO	Persistent cough or cold	❑ YES	❑ NO
Kidney trouble	❑ YES	❑ NO	Radiation treatment	❑ YES	❑ NO
Thyroid disease	❑ YES	❑ NO	Rheumatoid arthritis	❑ YES	❑ NO
Seizure disorder	❑ YES	❑ NO	Mental Health Disorder	❑ YES	❑ NO
Bleeding disorder	❑ YES	❑ NO	Panic anxiety	❑ YES	❑ NO
Anemia	❑ YES	❑ NO	Depression	❑ YES	❑ NO

If you answered yes to any of the above questions, please explain:

Do you have any disease, condition, or problem not listed above about which we should know? Please explain:

Important! Please fill out and sign the back side of this form.

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Dental History

How many times per year do you get your teeth CLEANED?	❑ 1	❑ 2	❑ 3	❑ 4	❑ only occasionally	❑ never
How many times a day do you BRUSH your teeth?	❑ 1	❑ 2	❑ 3	❑ occasionally	❑ after meals	
Do you use an ELECTRIC toothbrush (if so, what brand)?	❑ YES	❑ NO				

How many times a day do you FLOSS?	❑ 0	❑ 1	❑ 2	❑ 3	❑ occasionally	❑ after meals
How many times a day do you use TOOTHPICKS?	❑ 0	❑ 1	❑ 2	❑ 3	❑ occasionally	❑ after meals
How many times a day do you use an INTERDENTAL or PROXABRUSH?	❑ 0	❑ 1	❑ 2	❑ 3	❑ occasionally	❑ after meals
How many times a day do you use SUPERFLOSS?	❑ 0	❑ 1	❑ 2	❑ 3	❑ occasionally	❑ after meals
How many times a day do you use RUBBER TIPS or STIMUDENTS?	❑ 0	❑ 1	❑ 2	❑ 3	❑ occasionally	❑ after meals

Do you use TOBACCO in any form (if so, what type and how often)? ❑ YES ❑ NO

If applicable, how long have you worn dentures?

Please check YES or NO to the following, provide details if possible.

Have you ever been given professional instructions on how to clean your teeth and gums?	❑ YES	❑ NO
Have you noticed any loosening of the teeth?	❑ YES	❑ NO
Has anyone in your family lost teeth because of periodontal disease or pyorrhea?	❑ YES	❑ NO
Are any of your teeth sensitive to hot or cold? If so, where?	❑ YES	❑ NO
Do your gums bleed? If so, where?	❑ YES	❑ NO
Are your gums tender or spongy or red? If so, where?	❑ YES	❑ NO
Have you had sore gums or abscesses of the gums? If so, where/when?	❑ YES	❑ NO
Do any of your teeth hurt to bite on? If so, where?	❑ YES	❑ NO
Do you have a problem with food packing between your teeth? If so, where?	❑ YES	❑ NO
Do you often experience bad taste or odor in the mouth?	❑ YES	❑ NO

Do you grind or clench your teeth?	❑ YES	❑ NO	Have you had braces (orthodontics)?	❑ YES	❑ NO
Do your jaw joints pop or click?	❑ YES	❑ NO	Do you have difficulty speaking?	❑ YES	❑ NO
Do you have difficulty swallowing?	❑ YES	❑ NO	Is there pain in your jaw joints?	❑ YES	❑ NO
Do you have headaches; if so, how often?	❑ YES	❑ NO	Are you very nervous in the dental office?	❑ YES	❑ NO
Do you have difficulty chewing food?	❑ YES	❑ NO	Have you ever fainted in the dental office?	❑ YES	❑ NO
Do you gag easily?	❑ YES	❑ NO			

Do you avoid going out in public because of your teeth or mouth?	❑ YES	❑ NO
Do you avoid smiling because of your teeth or mouth?	❑ YES	❑ NO
Do you avoid certain types of foods due to dental disease or mouth comfort?	❑ YES	❑ NO
Do you think your teeth are affecting your health in any way?	❑ YES	❑ NO
Have you ever had a negative or traumatic experience in the dental office?	❑ YES	❑ NO
Have you ever had an injury to your face or jaws?	❑ YES	❑ NO
Are you pleased with your partial or denture (removable or bridge)?	❑ YES	❑ NO
Do you like the appearance of your teeth?	❑ YES	❑ NO

What MEDICATION(S), if any, are you currently taking (e.g. antibiotics, aspirin, steriod, insulin, anticoagulant, HRT, medicine for high blood pressure, etc.)?

Please provide any other comments you feel may be appropriate to your needs.

Responsibility and Consent Statement

If I have any change in health, I will inform the doctor at the beginning of my next visit.

Signature of *Patient*: **Date:**

Signature of *Doctor*: **Date:**