Dr.GeorgeGalluzzo, D.M.D.

Dental Health History
(Private & Confidential)

Patient Name ____________ (Last) ____________ (First) ______ (Initial) Birth Date ____________

Dental History

Reason for Today's Visit ______________________________

Former Dentist ______________________________

Address ______________________________

Date of last dental care ____________ Date of last dental X-rays ____________ Use "Water-pik"? ______

Click box if you have had problems with any of the following;

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Peridontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?____________ How often do you brush? ____________

Medical History

Physician's Name ______________________________ Date of last visit ____________

Have you had any serious illnesses or operations? ____________ If yes, pls. describe ____________

Have you ever had a blood transfusion? ____________ If yes, pls. give approximate dates ______

(Women) Are you Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Click box if you have or have had any of the following;

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems

Describe: ____________

- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Value Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Medications

List medications you are currently taking: ____________

____

____

____

Pharmacy Name ____________ Phone ____________

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: ____________

Signature

The above infomation is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ______________________________ Date ____________

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Dental Health History
(Private & Confidential)

Patient Information

Address ____________________

City ____________ State ____________ Zip code ________

Phone ____________ Social Security ____________

Date of Birth ____________ Marital Status ____________

Email ____________________

Preffered method of contact? ☐ **Email** ☐ **Phone** ☐ **Mail**

Appointment scheduling? ☐ **Email** ☐ **Phone** ☐ **SMS Text**

Would you like your X-rays available online? (secure cloud-based) ☐ **Yes** ☐ **No**

How were you reffered to us? ____________

Would you like to receive our quaterly newsletter? ☐ **Yes** ☐ **No**

Insurance Information

Primary Dental Insurance

Address ____________________

City ____________ State ____________ Zip code ________

Phone ____________ Group/Policy # ____________

Employment Information

Employer Name ____________________

Address ____________________

City ____________ State ____________ Zip code ________

Phone ____________

Payment

Please choose form of payment:

☐ **Cash** ☐ **Check** ☐ **Visa/MC** ☐ **Amex** ☐ **Discover** ☐ **Insurance** ☐ **ITEX**

I understand I am responsible for all unpaid balances including reasonable collection costs, attorney fees and late charges and possible interest penalites.

Signature: ____________________ Date: ____________