Welcome

DellaVecchia Dental Services, P.C.

Tracey DellaVecchia, DDS **Martin Raebel, DDS**

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help.

Patient # _____

SS# / SIN _____

Date _____

Patient Information (Confidential)

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

E-mail _____ Birthday _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience we offer the following methods of payment. Please check which your prefer. Payment at full at each appointment.

☐ Cash Personal ☐ Check Credit Card ☐ Visa ☐ Mastercard ☐ Care Credit

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# / SIN _____ Date Employed _____

Name of Employer _____ Union or Local #_____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy / ID#_____

Ins. Co. Address _____ City _____ State _____ Ziip_____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# / SIN _____ Date Employed _____

Name of Employer _____ Union or Local #_____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy / ID#_____

Ins. Co. Address _____ City _____ State _____ Ziip_____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

PATIENT NAME: _____ DATE OF BIRTH: _____

Often, there are important dental considerations with medications you may be taking or medical conditions you may have. Also, it is required by law that we obtain annual updates of our patient's physical health and medications. We thank you for filling this information out completely and honestly.

PHYSICIAN (if you have one): _____

PHYSICIAN'S PHONE (if you know it): _____ PLEASE CIRCLE

Have you been hospitalized or had a major operation within the last year?	◯YES ◯NO	If yes, explain: _____
Have you had a serious head or neck injury within the last year?	◯YES ◯NO	If yes, explain: _____
Have you ever had surgery on your heart?	◯YES ◯NO	If yes, explain: _____
Have you had Joint Replacement Surgery? Most commonly hip or knee?	◯YES ◯NO	If yes, explain: _____
Are you taking any medications for osteoporosis?	◯YES ◯NO	If yes, explain: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? PLEASE CIRCLE THOSE THAT APPLY TO YOU OR "NONE".

☐ASPIRIN ☐PENICILLIN ☐METALS ☐LATEX ☐SULFA ☐LOCAL ANESTHESIA Other : _____ NONE ☐

Please list your current medications: _____ NONE ☐

WOMEN ONLY: Please circle if applicable or circle "none".

☐CURRENTLY PREGNANT _____ WEEKS ☐NURSING ☐TRYING TO BECOME PREGNANT ☐TAKING ORAL CONTRACEPTIVES ☐NONE

PLEASE PLACE AN "X" NEXT TO ANY CONDITIONS THAT APPLY TO YOU OR CIRCLE "NONE".

☐ AIDS/HIV
☐ ALZHEIMERS
☐ ANAPHYLAXIS
☐ ARTHRITIS
☐ ARTIFICIAL HEART VALVE
☐ ASTHMA
☐ CANCER
☐ CHEMOTHERAPY
☐ COLD SORES
☐ GERD
☐ DIABETES
☐ DRUG ADDICTION
☐ EMPHYSEMA
☐ EPILEPSY
☐ DIARRHEA
☐ FIBROMYALGIA
☐ HERPES
☐ GLAUCOMA
☐ HEART ATACK
☐ HEART DEFFECT (AS CHILD)
☐ HEMOPHILIA
☐ HEPATITIS A
☐ HEPATITIS B OR C
☐ HIGH BLOOD SUGAR
☐ HYPOGLCEMIA
☐ INTESTINAL DISEASE
☐ IRREGULAR HEART BEAT
☐ KIDNEY DISEASE
☐ LIVER DISEASE
☐ MENOPAUSAL SYMPTOMS
☐ SICKLE CELL DISEASE
☐ STROKE
☐ THYROID DISEASE
☐ RADIATION THERAPY
☐ HORMONE REPLACEMENT
☐ CORTISONE THERAPY
☐ PERSISTANT PAIN

NONE ☐

OTHER:_____

Patient Dental History

PLEASE PLACE AN "X" NEXT TO ANY CONDITIONS THAT APPLY TO YOU OR CIRCLE "NONE".

☐ BLEEDING GUMS
☐ HOT SENSITIVE TEETH
☐ COLD SENSITIVE TEETH
☐ CLENCHING/GRINDING
☐ PERSISTANT TOOTH PAIN
☐ FREQUENT HEADACHES
☐ UNREPAIRED DECAY
☐ PAIN WHEN BITING
☐ HAD ROOT CANALS
☐ HAD BRACES
☐ REQUIRE IV SEDADTION FOR EXTRACTIONS
☐ HAD WISDOM TEETH REMOVED
☐ OBTRUSIVE SNORING

NONE ☐

OTHER: _____

Authorization and Release

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 payors 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 may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

X_____

Signature of patient (or parent/guardian if minor) In case of minor, please circle your relationship to patient: ◯Self ◯Mother ◯Father ◯Guardian