DR. ROCCO DeSantis, DDS **501 E Kay St., Kilgore, TX 75662** **Phone 903-984-4231**

1 ABOUT YOU

Today's Date

Email Address:

Name

Last First MI Mr Mrs Ms Dr

I prefer to be called: ☐Male ☐ Female

Birthday / / Age SS#

Home Address

Apt/Condo #

City State Zip

☐Single ☐Married ☐Partnered ☐Divorced/Separated ☐Widowed

Hm#: ( ) Cell/Other#:

Wk#: ( ) Ext: DL#:

Employer:

Empployer's Address:

City State Zip

How long there? Occupation

Where & when are best times to reach you?

Whom may we Thank for referring you?

Other family members seen by us:

Previous / Present Dentis:

Person responsible for account:

2 SPOUSE INFORMATION

His / Her Name:

Employer:

Wk#: ( ) Ext: DL#:

Empployer's Address:

City State Zip

Birthday / / DL#

Relative or Friend not living with you.

Name: Relation:

Employer:

Wk#: ( ) Hm#: ( )

3 INSURANCE

PRIMARY INSURANCE

Dental Coverage? ☐Yes ☐ No

Insurance Co. Name:

Insurance Co. Address

City State Zip

Insurance Co. Phone#( )

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

Insured's Name: Relation:

Birthday / / Insured's ID #

Insured's Employer:

Employer's Address:

Apt/Condo #

City State Zip

SECONDARY INSURANCE

Dental Coverage? ☐Yes ☐ No

Insurance Co. Name:

Insurance Co. Address

City State Zip

Insurance Co. Phone#( )

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

Insured's Name: Relation:

Birthday / / Insured's ID #

Insured's Employer:

Employer's Address:

Apt/Condo #

City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand taht I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature Date

DR. ROCCO DeSantis, DDS **501 E Kay St., Kilgore, TX 75662** **Phone 903-984-4231**

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:

Phone # ( ) Date of last visit

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain:

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gaspinig for breath? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter drugs?
☐ Yes ☐ No | Please list each one:

Have you ever taken Fosamax, or any other bisphosphonate?
☐ Yes ☐ No

For women: Are you using a prescribed method of birth control?
☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____
Are you nursing? ☐ Yes ☐ No

SECONDARY INSURANCE

Dental Coverage? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding/Hemophilia	Y N Herpes / Fever Blisters
Y N AIDS	Y N High Blood Presure
Y N Alcohol / Drug Abuse	Y N HIV
Y N Anemia	Y N Hospitalised for any reason
Y N Arthritis	Y N Kidney Problems
Y N Aritifical Bones / Joints / Valves	Y N Liver Disease
Y N Asthma	Y N Low Blood Pressure
Y N Blood Transfusion	Y N Lupus
Y N Cancer / Chemotheraphy	Y N Mitral Valve Prolapse
Y N Colitis	Y N Pacemaker
Y N Congenital Heart Defect	Y N Psychiatric Treatment
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing	Y N Rheumatic / Scarlet Fever
Y N Emphysema	Y N Seizures
Y N Epilepsy	Y N Shingles
Y N Fainting Spells	Y N Sickle Cell Disease / Traits
Y N Frequent Headaches	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Hay Fever	Y N Thyroid Problems
Y N Heart Attack / Surgery	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers
Y N Hepatitis	Y N Veneral Disease

Please list any serious medical conditions(s) that you have ever had:

Are you allergic to any of the following:

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jelwery / Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

Please list any other drugs / materials that you are allergic to:

5 DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? ☐ Yes ☐ No

Did you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatmen? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else?

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath ☐ Yes ☐ No Whiter teeth ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what you change?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature Date

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit?
☐ Yes ☐ No | If yes, please explain:

Patient Signature Date

Dentist Signature Date

Has there been any change in your health status since your last visit?
☐ Yes ☐ No | If yes, please explain:

Patient Signature Date

Dentist Signature Date