



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 circle 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 circle 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 circle 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 Bisphosphonates (Bone Meds) |
| 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