Patient Information:

Name_____ Preferred Name _____ Birth Date _____ Sex _____
First Last M. initial

Address _____
Street City Zip

Home Phone (____) _____Work Phone (____) _____ Cell Phone (____) _____

E-mail address _____

Patient Employer _____ Occupation _____

Spouse _____Children _____

Whom may we thank for referring you to our office? _____

If Child, Responsible Party Information:

Name _____ Phone Number (____) _____

Address _____
Street City Zip

Insurance Information:

Name of Person Insured _____ Birth Date _____

Social Security Number or Employee ID _____

Insurance Company _____ Group Number _____

Insurance Company Phone Number (____) _____ Employer _____

Insurance Company Address _____
Street City Zip

Dental Insurance may cover only a portion of your dental treatment. It is understood that you (or responsible party) are responsible for any balance not covered by insurance. Delinquent accounts may be assessed a finance charge.

I authorize my insurance company to pay Dr. Casciari directly for services rendered. I authorize release of any dental information to process claims or to other health care providers as is necessary in the course of my dental treatment.

Signature _____ Date _____

Medical History:

Are you allergic to anything? Yes ( ) No ( )

If yes, please list allergies: _____

_____

Are you allergic to latex? Yes ( ) No ( )

Are you allergic to any metals? Yes ( ) No ( )

Have you ever had any excess bleeding requiring special treatment? Yes ( ) No ( )

Have you ever experienced any ill effects from a local anesthetic ? Yes ( ) No ( )

Do you have a pacemaker? Yes ( ) No ( )

Are you pregnant now? Yes ( ) No ( )

Have you taken bisphosphonate medications such as Fosamax? Yes ( ) No ( )

Do you smoke or use chewing tobacco? Yes ( ) No ( )

Are you currently taking any prescription medications? Yes ( ) No ( )

If yes, please list medication and purpose:

Drug	Purpose

Have you ever had any of the following?

Heart Trouble - including Angina	Yes ( ) No ( )
Heart Infection (Endocarditis)	Yes ( ) No ( )
High Blood Pressure	Yes ( ) No ( )
Tuberculosis	Yes ( ) No ( )
Nervous Disorders	Yes ( ) No ( )
Diabetes	Yes ( ) No ( )
Radiation Treatment (to head or neck)	Yes ( ) No ( )
Blood Diseases	Yes ( ) No ( )
Liver Diseases	Yes ( ) No ( )
Kidney Diseases	Yes ( ) No ( )
Hepatitis or Jaundice	Yes ( ) No ( )
Tumors or Growths	Yes ( ) No ( )
Asthma	Yes ( ) No ( )
Epilepsy	Yes ( ) No ( )
AIDS or HIV positive	Yes ( ) No ( )
Stroke	Yes ( ) No ( )
Prosthetic (artificial) Joints	Yes ( ) No ( )

Please list any other serious illness you have had and any current medical treatment:

_____

_____

_____

_____

_____

_____

_____

Signature_____ Date _____

Please let us know if you would like to talk privately with the doctor about your medical history.

Questionnaire Update:

Date					
Initials					