Kimberley Capua, DDS, PA

Family and Cosmetic Dentistry

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PATIENT I.D. #

FOR OFFICE USE ONLY

Date	Insurance	Date	Insurance

LAST NAME FIRST NAME M.I NAME THAT YOU WISH TO BE CALLED | HOME PHONE # ( ) | BUS. PHONE # ( )

SPOUSE'S NAME IN FULL | GUARDIAN'S NAME IN FULL | PATIENT'S CELLPHONE # ( )

HOME ADDRESS/Include Apt.# CITY STATE ZIP CODE | EMAIL ADDRESS

I prefer to be contacted: Check all that apply

☐ Home Telephone ☐ Work Telephone ☐ Email ☐ Written Communication ☐ Cell Phone

I allow to give my clinical information to or answer Questions from: Check all that apply

☐ Spouse ☐ Parent ☐ Child ☐ Other (specify) ☐ None

SOCIAL SECURITY # | DATE OF BIRTH | AGE | M/F | MARITAL STATUS | DRIVERS LICENSE #

PARENTS NAME - If 18 yrs. or younger | MOTHER'S WORK # ( ) | FATHER'S WORK# ( ) | INDIVIDUAL RESPONSIBLE FOR PAYMENT

NAME OF INSURANCE COMPANY | INSURED'S SOCIAL SECURITY # | GROUP #

PATIENT'S OR GUARDIAN'S EMPLOYMENT | OCCUPATION

BUSINESS ADDRESS CITY STATE ZIP CODE

SPOUSE'S EMPLOYMENT | OCCUPATION | BUS. PHONE# ( )

REFERRED TO OFFICE BY | MEDICAL DOCTOR | MEDICAL DR. TELEPHONE #

PURPOSE OF VISIT | PREVIOUS D.D.S. AND THEIR TELEPHONE # ( )

HAVE WE TREATED ANY OF YOUR FAMILY OR FRIENDS? | WHO?

EMERGENCY CONTACT TELEPHONE # ( ) | NEAREST LIVING RELATIVE TELEPHONE # ( )

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I have read the "Notice of Privacy Practices for protected Health Information", I have asked and had answered any questions pertaining to that document. And I have filled out my preferences for patient disclosure information.

5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents, I understand that payment is due at the time of services unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. In the event of default, I promise to pay any legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to collect this note.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____

Health History

Answers to the following questions are for our records only and will be considered confidential.

1. Date of last Physical Examination _____ Reason: _____
2. Date of last Dental Examination _____ Date of last Dental X-Rays _____
3. Date of last Dental Cleaning _____ Findings: _____

CIRCLE

YES NO 4. Are you having pain or discomfort at this time? Explain: _____
YES NO 5. Do you feel very nervous about having dental treatment? _____
YES NO 6. Is there anything that you dislike about your smile? Explain: _____
YES NO 7. Have you been a patient in the hospital during the past 5 years? Reason: _____
YES NO 8. Have you been under the care of a medical doctor during the past two years? Reason: _____
_____
YES NO 9. Have you ever received IV or oral bisphosphonates? (i.e., Aredia, Zometa, fosamax, Reclast)
YES NO 10. Are you currently taking any medications? Please list: _____
_____
YES NO 11. Are you Allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or other drugs, medications? _____
YES NO 12. Are you allergic to any form of metals (i.e., jewelry)? _____
YES NO 13. Do you have any food allergies? Specifically: Bananas, Avocado, Nuts, Kiwi, or Melon,
Other _____
Please circle all that apply.
YES NO 14. Have you ever had any excessive bleeding requiring special treatment? _____
YES NO 15. Are you currently taking: Ginseng, Gingko Biloba, Garlic, Vit. E, or St. John's Wort? (Circle)

Circle any of the following which you have had or have at present:

Heart Failure
Heart Disease or Attack
Chest Pains
High Blood Pressure
Use of Tobacco Products
Thyroid Disease
Heart Pacemaker
Heart Surgery
Cancer (type:_____)
Anemia
Stroke
Mitral Valve Prolapse
Heart Murmur
Rheumatic Fever

Ulcers
Emphysema
Cough
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes
Sexually Transmitted Disease
Radiation Therapy
Chemotherapy
Arthritis
Fainting or Dizzy Spells
Osteoporosis
Kidney Trouble

Glaucoma
Pain in Jaw Joints
Birth Defects
HIV Positive, ARC, AIDS
Hepatitis: (type:_____)
(Yr. occurred: _____)
Liver Diseases
Jaundice
Blood Transfusion
Drug Addiction
Hemophilia
Any type of Transplant
Cold Sores
Fever Blisters
Alcoholism

Any Type of Implant
(Heart Valve, etc.)
Psychiatric Treatment
Sickle Cell Disease
Bruise Easily
Artificial Hip, Knee or
other Joint Replacement
Latex Sensitivity
Tumors (type: _____)
(location: _____)
Neurological Disorders
Nervous/Anxious Disorders
Epilepsy or Seizures
Cortisone Medication

CIRCLE

YES NO 16. Have you ever had any instructions in oral hygiene? _____
YES NO 17. Are there now any growths or sores in or around your mouth? _____
YES NO 18. Do you have any trouble chewing? _____
YES NO 19. Does food catch between your teeth? _____
YES NO 20. Do you have pain in or near your ears?: _____
YES NO 21. Do you habitually clench or grind your teeth during the day or night? _____
YES NO 22. Have you ever been told that you have gum problems? _____
YES NO 23. Do you now have bleeding gums or any other gum conditions? _____
YES NO 24. WOMEN: Are you pregnant now? _____
YES NO 25. I understand that antibiotics, if prescribed, may reduce the effectiveness of birth control pills and an alternate method should be used.
YES NO 26. Is there anything related to your medical or dental history that you have not indicated above?
If yes, Explain: _____
_____

Patient/Parent/Guardian Signature _____ DATE _____