Dr. Teri Downes and Dr. Catharine Farinelli welcome you to our office!

PERSONAL INFORMATION

Name_____Birthdate_____Soc. Sec. # _____Male___ Female___

Address _____City/State/Zip Code _____

Phone _____ Cell _____Email_____ Marital Status M ___D ___ S ____

Employer _____ Phone _____ Emergency Contact _____ Phone _____

If patient is a child, name of Parent/Guardian _____Relationship _____

Who is responsible for bill _____ Address _____ Phone _____

INSURANCE INFORMATION

Policy Name _____ ID# _____ Policy Holder _____ Birthdate_____

Home Address _____Employer _____Relationship to Patient _____

Please check all of the following that apply to you or have ever applied to you.

___ AIDS/HIV Positive
___ Acid Reflux
___ Alzheimer's Disease
___ Anaphylaxis
___ Anemia
___ Angina
___ Arthritis/Gout
___ Artificial Heart Valve
___ Artificial Joint
___ Asthma
___ Blood Disease
___ Blood Transfusion
___ Breathing Problems
___ Bruise Easily
___ Cancer
___ Chemotherapy
___ Chest Pains
___ Cold Sores/Fever Blisters
___ Congenital Heart Disorder
___ Convulsions
___ Cortisone Medicine
___ Diabetes
___ Drug Addiction
___ Easily Winded
___ Emphysema
___ Epilepsy or Seizures
___ Excessive Bleeding
___ Excessive Thirst
___ Fainting/Dizziness
___ Frequent Cough
___ Frequent Diarrhea
___ Frequent Headaches
___ Genital Herpes
___ Glaucoma
___ Have a CPAP machine
___ Hay Fever
___ Heart Attack/Failure
___ Heart Trouble or murmur
___ Hemophilia
___ Hepatitis A
___ Hepatitis B or C
___ Herpes/Venereal Dis.
___ High Blood Pressure
___ High Cholesterol
___ Hives
___ Hypoglycemia
___ Irregular Heartbeat
___ Kidney Problems
___ Leukemia
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___ Mitral Valve Prolapse
___ Need Premedication
___ Osteoporosis
___ Pain in Jaw Joints
___ Parathyroid Disease
___ Pregnant currently
___ Psychiatric Care
___ Radiation Treatment
___ Recent Weight Loss
___ Renal Dialysis
___ Rheumatic Fever
___ Scarlet Fever
___ Shingles
___ Sickle Cell Disease
___ Sinus Trouble
___ Sleep Apnea
___ Snoring
___ Spina Bifida
___ Stomach/Intestinal Disease
___ Stroke
___ Swelling of limbs
___ Taken bisphosphonates
___ Taken Phen-Fen or Redux
___ Taken Fosamax, Boniva, Actonel
___ Taking oral contraceptives
___ Thyroid disease
___ Tired, excessively
___ Tonsillitis
___ Tuberculosis
___ Tumors or Growths
___ Ulcers
___ Use Tobacco Products
___ Use Controlled Substances
___ Yellow Jaundice

___ Premed needed

MEDICATIONS: Please list ALL medications you take, including vitamins and herbal supplements.

_____

_____

Are you allergic to any of the following? __Aspirin __Penicillin __Codeine __Metal __Latex __Sulfa drugs
__Local anesthetics Other allergies_____

Have you needed a physician's care or been hospitalized in the last year? ____ Yes ____ No

If yes, Dr.'s name and reason for needing care _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that I am financially responsible for all charges whether or not paid by insurance. Accounts not paid within 90 days are subject to additional collection fees and legal fees.

SIGNATURE _____ Date _____