LOUIS F. CLARIZIO, DDS PA

ORAL SURGERY & DENTAL IMPLANT CENTER

Date_____

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____M.I.____Last Name_____Nickname_____

Sex: ❑ Male ❑ Female DOB_____Age____ Soc. Sec. #_____E-Mail_____

Street_____City_____State_____Zip_____

Home Tel. (_____) _____Cell.(_____) _____

Dentist_____ _____Medical Doctor_____ _____Referred By_____ _____
First Name Last Name First Name Last Name First Name Last Name

Employer_____Address_____Bus. Tel. (_____) _____

Who will be responsible for your account?

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

(If self, skip to next section)

Name_____ _____ S.S.# _____ DOB_____Age___ Tel. (____) _____
First Name Last Name

Street_____City_____State_____Zip_____

Employer_____Bus. Tel. (_____) _____

Spouse or other guarantor information *(if different from above)*

Name_____ _____ Relation_____ S.S.#_____ DOB_____
First Name Last Name

Street_____City_____State_____Zip_____

Tel. (_____) _____Employer_____Bus. Tel. (_____) _____

INSURANCE INFORMATION

Student: ❑ Full Time ❑ Part Time ❑ Not

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not

School Info

_____ _____
SCHOOL NAME ADDRESS

_____ _____ _____
CITY STATE ZIP

PRIMARY DENTAL INSURANCE COMPANY

Employer_____

Bus. Address_____
ADDRESS CITY STATE ZIP

Bus. Tel. (____)_____Plan_____

Ins. Co. Name_____

Address_____
ADDRESS

_____ _____ _____ Tel. (____)_____
CITY STATE ZIP

Group #_____Group Name_____

Insured Party_____ _____Relation_____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F DOB_____

Address_____

_____ _____ _____
CITY STATE ZIP

Tel.(____) _____S.S. #_____

I.D. # _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer_____

Bus. Address_____
ADDRESS CITY STATE ZIP

Bus. Tel. (____)_____Plan_____

Ins. Co. Name_____

Address_____
ADDRESS

_____ _____ _____ Tel. (____)_____
CITY STATE ZIP

Group #_____Group Name_____

Insured Party_____ _____Relation_____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F DOB_____

Address_____

_____ _____ _____
CITY STATE ZIP

Tel.(____) _____S.S. #_____

I.D. # _____

Do you have a secondary dental and/or medical insurance? ❑ Yes ❑ No

HEALTH QUESTIONNAIRE

Primary care provider _____ Last visit _____ Phone # _____

Cardiologist or Specialist _____ Phone # _____

Have you been hospitalized for a serious illness in the last 5 years? YES or NO

If yes, why _____

Are you under the care of a pain clinic? YES or NO Treatment Center Name _____ Phone # _____

CIRCLE ANY THAT APPLY TO YOU

Heart disease/attack (date)_____	Cancer (what type) _____	Emphysema	IBS	Smoke
Stents (date placed)_____	(if breast) RIGHT or LEFT	Asthma	HIV/AIDS	Street drugs
Artificial heart valve	Chemotherapy	Allergies	Hepatitis C	Chew/tobacco
Pacemaker	Radiation (area) _____	Sinus trouble/surgeries	Liver disease	*Gag Reflex*
Heart murmur	Rheumatic fever	Epilepsy or seizures	Hemophilia	Stomach ulcers
Mitral valve prolapse	Tuberculosis	Diabetes (insulin, pills, diet)	Glaucoma	Anemia
Angina	Stroke	Thyroid disease	Kidney trouble	Anxiety/panic attacks
A-FIB	High blood pressure	Artifical joint	Arthritis	

PLEASE LIST ALL MEDICATIONS

_____

_____

_____

PLEASE CIRCLE

YES or NO Have you or any family member had any adverse reaction to anesthesia? Explain_____

YES or NO Sleep Apnea (C-PAP Mask)?

YES or NO Difficult veins when having blood work or IV's?

YES or NO History of taking a lot of antibiotics (even as a child) (strep throat, bronchitis, ear infections (tubes in ears), sinus infection, lyme)?

YES or NO Premedicate with Antibiotics prior to dental appointments?

YES or NO Clicking or popping of jaw joint?

YES or NO Grind or clench your teeth?

YES or NO History of taking medications for acne (Doxycycline or Tetracycline)?

Women: Circle if: Pregnant Possibly Pregnant Nursing or Taking birth control

Do you take any blood thinners? Coumadin Plavix Aspirin 81mg or 325mg or other_____

Do you take or have you ever taken bone strengtheners?
Fosamax Boniva Actonel Reclast Zomeda Aredia or other_____
When did you start?_____ How long did you take them?_____Stop date_____

YES or NO Do you take steroids? (prednisone etc.) How long did you take them? _____

YES or NO Do you use/have an inhaler? How often used Weekly Monthly Seasonal Exercise Induced

PLEASE CIRCLE ALLERGIES

Local anesthetic	Sulfur drugs	Pentothal, Valium/Tranquilizers	LATEX
Penicillin/Amoxicillin	Aspirin	Morphine	Soy
Other antibiotics	Codeine or other narcotics	OTHER_____	

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE AND THAT I WILL HAVE THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR DURING THIS APPOINTMENT

SIGNATURE_____DATE_____REVIEWED BY DR_____