

Paul V. Caputo, D.D.S.

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____
Full Time Student Where _____
Birth Date: _____ Social Security #: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City State Zip Code
Referred By: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment
Patient Name: _____
 Male Female Married Single Child Other _____ Drivers License # _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City State Zip Code

Insurance Information

Primary Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship in insured: Self Spouse Child Other
Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and agree to their content.
Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

PLEASE COMPLETE BOTH SIDES OF FORM — THANK YOU!

HEALTHY HISTORY

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand the question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
4. Yes No Are you being treated by a physician now? For what? _____
Date of last Medical Exam? _____ Date of last Dental Appt? _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED?

- | | |
|---|-----------------------------------|
| 7. Yes No Chest pain (angina)? | 18. Yes No Dizziness? |
| 8. Yes No Swollen ankles? | 19. Yes No Ringing in ears? |
| 9. Yes No Shortness of breath? | 20. Yes No Headaches? |
| 10. Yes No Recent weight loss, fever, night sweats? | 21. Yes No Fainting spells? |
| 11. Yes No Persistent cough, coughing up blood? | 22. Yes No Blurred vision? |
| 12. Yes No Bleeding problems, bruising easily? | 23. Yes No Seizures? |
| 13. Yes No Sinus problems? | 24. Yes No Excessive thirst? |
| 14. Yes No Difficulty swallowing? | 25. Yes No Frequent urination? |
| 15. Yes No Diarrhea, constipation, blood in stools? | 26. Yes No Dry mouth? |
| 16. Yes No Frequent vomiting, nausea? | 27. Yes No Jaundice? |
| 17. Yes No Difficulty urinating, blood in urine? | 28. Yes No Joint pain, stiffness? |

III. DO YOU HAVE OR HAVE YOU HAD?

- | | |
|--|--|
| 29. Yes No Heart disease? | 40. Yes No AIDS or ARC? |
| 30. Yes No Heart attack, heart defects? | 41. Yes No Tumors, cancer? |
| 31. Yes No Heart murmurs? | 42. Yes No Arthritis, rheumatism? |
| 32. Yes No Rheumatic fever? | 43. Yes No Eye diseases? |
| 33. Yes No Stroke, hardening of arteries? | 44. Yes No Skin diseases? |
| 34. Yes No High blood pressure? | 45. Yes No Anemia? |
| 35. Yes No TB, asthma, emphysema, other lung diseases? | 46. Yes No VD (syphilis or gonorrhea)? |
| 36. Yes No Hepatitis, other liver disease? | 47. Yes No Herpes? |
| 37. Yes No Stomach, Problems, ulcers? | 48. Yes No Kidney, bladder disease? |
| 38. Yes No ALLERGIES: to drugs, foods, medications? | 49. Yes No Thyroid, adrenal disease? |
| 39. Yes No Family history of diabetes, heart problems, tumors? | 50. Yes No Diabetes? |

IV. DO YOU HAVE OR HAVE YOU HAD?

- | | |
|------------------------------------|--------------------------------|
| 51. Yes No Psychiatric care? | 56. Yes No Hospitalization? |
| 52. Yes No Radiation treatments? | 57. Yes No Blood transfusions? |
| 53. Yes No Chemotherapy? | 58. Yes No Surgeries? |
| 54. Yes No Prosthetic heart valve? | 59. Yes No Pacemaker? |
| 55. Yes No Artificial joint? | 60. Yes No Contact lenses? |

V. ARE YOU TAKING?

- | | |
|--|---------------------------------|
| 61. Yes No Recreational drugs? | 63. Yes No Tobacco in any form? |
| 62. Yes No Drugs medicines, (incl. Aspirin)?
Please list: _____,
_____ | 64. Yes No Alcohol? |

IV. WOMEN ONLY:

- | | |
|---|--|
| 65. Yes No Are you or could you be pregnant or nursing? | 66. Yes No Taking birth control pills? |
|---|--|

VII. ALL PATIENTS:

67. Yes No Do you have or have had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's Signature _____ Date _____

RECALL REVIEW:

1. Patient's Signature _____ Date _____
2. Patient's Signature _____ Date _____
3. Patient's Signature _____ Date _____