Romeo Family Dentistry

Welcome!

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us we will be happy to help .

Patient Information (Confidential)

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Soc. Sec. # _____ Birthdate _____ Home Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birthdate _____ SS # _____

Insurance Information

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DENTAL MEDICAL HISTORY

Are you allergic to any medication? Any other substance? _____

Are you taking any medication now or in the last year? If yes, please list medication & dosage.

Medication	Dosage	Reason	Medication	Dosage	Reason

Have you been under a physician's care in the last 2 years? If yes, please note _____

_____

Do you have or have you had any of the following?

AIDS or HIV	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Art. Heart Valve	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Other Conditions	_____
Cancer	☐ Yes ☐ No	Latex Allergies	☐ Yes ☐ No		_____
Cardiac Pacemaker	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No		_____
Diabetes	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Pace Maker	☐ Yes ☐ No		
Heart Attack	☐ Yes ☐ No	Prosthetic Joint	☐ Yes ☐ No		

Have you had any other serious illness?	☐ Yes ☐ No
If female, are you or could you be pregnant now?	☐ Yes ☐ No
Do you have sensitive teeth/gum tissue?	☐ Yes ☐ No
Do you have any sore spots, inflamed areas, swelling?	☐ Yes ☐ No
Do your gums bleed while brushing or flossing?	☐ Yes ☐ No
Have you had prolonged bleeding following extractions?	☐ Yes ☐ No
Do you like your smile?	☐ Yes ☐ No

List any dental complaints: _____

_____

I authorize Romeo Family Dentistry to release any information including diagnosis & treatment rendered to me or my child to my insurance company. I authorize Romeo Family Dentistry to submit insurance claims on behalf of myself or dependents. I will be responsible for balances not covered by my insurance company including deductible, co-pays & non-covered services. Clams not paid by insurance after 90 days will be transferred to me for resolution. A fifteen dollar collection fee will be assessed for balances delinquent 90 days or more unless a prior payment arrangement is on file.

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____