



Welcome To Our Office!

*Thank you for trusting us with your dental care.
We promise to do our best to provide you with the finest care available.
If you have any questions please do not hesitate to call us.*

PATIENT INFORMATION

Patient _____ Date _____
 Address _____

 City _____ State _____ Zip _____
 Sex M F Age _____ Birthdate _____
 Single Married Widowed Separated Divorced
 Patient SS# _____
 Occupation _____
 Employer _____
 Employer Address _____
 Employer Phone _____
 Spouse's Name _____
 Birthdate _____ SS# _____
 Occupation _____
 Spouse's Employer _____
 Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

 Relationship to Patient _____
 Insurance Co. _____
 Group # _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Drs. Bonar and Basso all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

 Relationship to Patient _____ Date _____

CONTACT INFORMATION

Home _____ Work _____ Ext _____ Cell _____
 Spouse's Work _____ Ext _____ Spouse's Cell _____
 E-Mail Address _____
 IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
 Name _____ Relationship _____
 Home Phone _____ Work Phone _____

Please Complete Both Sides

HEALTH HISTORY

Physician's Name _____ Phone _____ Date of last visit _____

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Women: Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Due date _____			
		Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MEDICATIONS

List medications you are currently taking: _____
 Have you, are you or will you be taking bisphosphonates medication (alendronate-Fosamax, risedronate-Actonel or IV drugs - Aredia or Zometa) for osteoporosis, Paget's disease or for any other reason? Yes No
 Have you ever taken Fen-Phen? Yes No Have you ever taken Redux? Yes No
 Pharmacy Name _____ Pharmacy Phone Number _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Other _____
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin	_____
	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa	_____

DENTAL HISTORY

Reason for Today's Visit _____
 Former Dentist _____
 Address _____
 Date of last dental care _____ Date of last dental X-rays _____
 Check (✓) if you have had problems with any of the following:
 Bad Breath Grinding teeth Sensitivity to hot
 Bleeding Gums Loose teeth or broken fillings Sensitivity to sweets
 Clicking or popping jaw Periodontal treatment Sensitivity when biting
 Food collection between teeth Sensitivity to cold Sores or growths in your mouth
 How often do you floss? _____ How often do you brush? _____

DATE	PATIENT'S/PARENT'S SIGNATURE	P/BP	DOCTOR'S SIGNATURE