

Verardi Dental

Last Name _____ First Name: _____
Address: _____ City: _____
State _____ Zip _____ Work #: _____
Cell #: _____ Home #: _____
Birth Date: _____ Age: _____ Male Female Married Single
Social Security Number: _____
Email address for cleaning appt reminders: _____

Dental Insurance

Name of Insurance Company _____
Insurance phone number: _____ Group# : _____
ID # or SS #: _____ Employer Name: _____
Name of card holder: _____ Birth date of card holder _____
Person to contact for emergency _____ Cell # _____

Our Mission Statement

To provide our community with the highest standard of dental care. In providing this exceptional care, we plan to cultivate satisfied, appreciative, and prevention-oriented patients. With quality care as our focus, we will strive to exceed our patient's expectations with respect to customer service, friendliness and compassion.

Your Dental History

Date of Last Dental Visit _____ Enter MM/DD/YYYY

What was done at your last dental visit? _____

Previous Dentist Name _____ Address _____ City _____

Phone # _____ State _____ Zip _____

Do you have any dental problems such as:

Are any of your teeth sensitive? Yes No

Do your gums bleed? Yes No

Are you satisfied with your teeth's appearance? Yes No

Are you wearing removable dental appliances? Yes No

Your Medical History

Are you now under the care of a physician? Yes No If so, for what condition? _____

Name and Address of my physician is: _____

Phone: _____

List any and all medicine(s) including non-prescription, homeopathic or "Natural" remedies including diet pills? _____

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

Damaged heart valves, artificial valves, heart murmur or MVP Yes No

Pacemaker Yes No

Rheumatic Heart Disease Yes No

Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis Yes No

Latex Sensitivity Yes No

Asthma or hay fever Yes No

Fainting spells, seizures, epilepsy or neurological disorder Yes No

Diabetes Yes No

HIV Yes No

Hepatitis, jaundice or liver disease Yes No

Frequent or recurring mouth sores Yes No

Thyroid problems Yes No

Respiratory problems, emphysema, bronchitis, etc Yes No

Arthritis or painful, swollen joints including jaw joint (TMJ) Yes No

Joint Replacement Yes No

Stomach ulcer or hyperacidity Yes No

Kidney trouble Yes No

Tuberculosis Yes No

Radiation treatment Yes No

If yes, body location _____

Do you have or have you had any disease, condition, or problem not listed? Yes No

Please Explain: _____

Are you allergic to any medications? Yes No

Please Explain: _____

Any other allergies (Please include: foods, such as eggs, metals, etc) Yes No

Please Explain: _____

Do you smoke? Yes No

Do you drink alcohol? Yes No

Are you pregnant or trying to become pregnant? Yes No

Are you taking birth control pills? Yes No