

# Verardi Dental

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Male / Female Married / Single

Social Security Number: \_\_\_\_\_

Email address for appointment 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 # \_\_\_\_\_

How were your **referred** to Verardi Dental: \_\_\_\_\_

### 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 \_\_\_\_\_ What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have any dental problems such as:

- \* Do your gums bleed? Yes No
- \* CIRCLE which appliance you currently wear: Dentures Partial Nightguard
- \* CIRCLE which dental concern you currently have: Grinding Clenching

# Your Medical History

Are you now under the care of a physician? \_\_\_\_\_ If so, for what condition? \_\_\_\_\_

The name, address, phone # of your physician: \_\_\_\_\_

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 listed below?

**CIRCLE** all items that apply to you below:

Please CIRCLE Yes or No

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/Low Blood Pressure, High/Low Cholesterol, 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
Cancer	Yes	No

If Yes, please explain: \_\_\_\_\_

Radiation treatment \_\_\_\_\_ Yes No  
If yes, body location \_\_\_\_\_

Do you have or have you had any disease, condition, or problem not listed? \_\_\_\_\_

Are you **allergic** to any medication? \_\_\_\_\_

Any other allergies (Please include: foods, such as eggs, metals, etc) \_\_\_\_\_

- Do you smoke? Yes No
- Do you drink alcohol? Yes No
- Are you pregnant? Yes No
- Are you taking birth control pills? Yes No

X  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_