Welcome to the office of Charles A. Picchioni, D.M.D., P.C.
Member of the American Dental Association

*Name(first)*_____*(mi)*____*(last)*_____

*Address*_____

*City*_____*State*___*Zip*_____*Phone*_____*Cell*_____

*Social Security #*_____ *Sex* ____*M* ____*F*

*Date of Birth*_____ __*Single* __*Married* __*Widowed* __*Divorced*

*Occupation*_____*Employer*_____

*Employer's Address*_____*Phone*_____

*If self employed, name of business/address*_____

Are you a full time student? ___*Yes* ___*No If yes, which school*_____

Responsible Party Information ONLY if under 18 or full time student

*Name(Father/Mother)*_____*S.S.#*_____

*Address*_____

*Phone*_____*Date of Birth*_____

*Employer*_____*Occupation*_____*Work#*_____

Dental Insurance Information

*Employee's Name*_____*S.S.#*_____

*Employer Name & Address*_____*Phone*_____

*Insurance Co.*_____*ID#*_____*Group#*_____

*Insurance Co. Address*_____*Phone*_____

Are you covered under another insurance plan? ___*YES* ___*NO*
*If yes, name of 2nd insurance company/address*_____
*Name of employee for second insurance company*_____
S.S # of employee for second insurance _____

I understand that as a service to me, the dental practice will assist me in processing my insurance claims. However, I am completely responsible for all fees in their entirety.

_____ _____
Signed (patient or parent if minor) *Date*

*Whom can we thank for referring you to Dr. Picchioni's office?*_____
*Person to notify in an emergency: Name*_____*Phone*_____

MEDICAL HISTORY

Your current physical health: ____Good ____Fair ____Poor
Are you currently under the care of a physician? ___Y ___N Reason_____
Name of physician_____ Phone_____

Do you smoke or use tobacco in any other forms? ___Y ___N If yes, how long?_____

Are you taking any prescriptions/over the counter drugs? ___Y ___N
Please list each one: _____

_____

Are you taking birth control pills? __Y __N Are you pregnant?__Y __N

Do you need to pre-medicate before dental visits? ___Y ___N
*Have you **EVER** had any of the following diseases or medical problems?*

Y N	Abnormal Bleeding	Y N	Hepatitis
Y N	Alcohol/Drug Abuse	Y N	Herpes/Fever Blisters
Y N	Anemia	Y N	High Blood Pressure
Y N	Angina	Y N	HIV+/AIDS
Y N	Arthritis	Y N	Hospitalized for any reason
Y N	Artificial Bone/Joints/Valves	Y N	Kidney Problems
Y N	Asthma	Y N	Liver Disease
Y N	Blood Transfusion	Y N	Low Blood Pressure
Y N	Caner/chemotherapy/radiation	Y N	Mitral Valve Prolapse
Y N	Colitis	Y N	Osteonecrosis
Y N	Congenital Heart Defect	Y N	Osteoporosis
Y N	Diabetes	Y N	Pacemaker
Y N	Difficulty Breathing	Y N	Psychiartic Problems
Y N	Emphysema	Y N	Rheumatic/Scarlet Fever
Y N	Epilepsy	Y N	Seizures
Y N	Fainting Spells	Y N	Shingles
Y N	Glaucoma	Y N	Sickle Cell Disease
Y N	Hay Fever/Sinus Problems	Y N	Stroke
Y N	Heart Attack	Y N	Thyroid Problems
Y N	Heart Murmur	Y N	Tuberculosis (TB)
Y N	Heart Surgery	Y N	Ulcers
Y N	Hemophilia	Y N	Venereal Disease

Please list any other serious medical condition(s) that you have ever had:_____
Are you taking any kind of blood thinners (i.e. aspirin, coumadin) _Y __N If so, what?_____

Are you Allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Sulfa
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Penicillin	Y N	Other

Please list any other drugs that you are Allergic to:_____

Reason for your visit _____

To the best of my knowledge the questions on this form have been accurately answered.

Signature_____ ***Date***_____

Welcome to the office of Charles A. Picchioni, D.M.D., P.C.
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Child Health History Form

Your child

Child's Name: _____
Last First MI
Nickname_____ Sex_____
Birth date:_____/_____/_____ Age:_____
Social Security #_____
Child's Home Address:_____

_____
City Sate Zip
Phone #:(___)_____
Person Responsible for account:_____
Relationship:_____
Telephone #

Mother Stepmother Guardian

Name:_____
E-Mail:_____
Home Phone #:_____
Work Phone #:_____
Social Security#:_____
Employer:_____
Occupation:_____

Father Stepfather Guardian

Name:_____
E-Mail:_____
Home Phone #:_____
Work Phone #:_____
Social Security#:_____
Employer:_____
Occupation:_____

Parent's Marital Status

Single Married
Divorced Widowed Separated

Primary Dental Insurance

Insured's Name:_____
Relationship:_____
Birth date:___/___/___ SS#:_____
Employer:_____ Date Employed_____
Occupation:_____
Insurance Company:_____
Insurance Co Phone #:_____
Group No:_____ Emp. No:_____
Insurance Co. Address_____
Ded:_____ Max Annual Benefit:_____
Orthodontic Coverage? Yes No

Additional Insurance

Insured's Name:_____
Relationship:_____
Birth date:___/___/___ SS#:_____
Employer:_____ Date Employed_____
Occupation:_____
Insurance Company:_____
Insurance Company:_____
Insurance Co Phone #:_____
Group No:_____ Emp. No:_____
Insurance Co. Address_____
Ded:_____ Max Annual Benefit:_____
Orthodontic Coverage? Yes No

Who is responsible for making appointments?

Name:_____
E-mail:_____
Relationship:_____
Home Phone #:_____
Work Phone #:_____
Best Time to Call: (Time)_____ Days_____

Medical History

Has your child had any difficulty with previous visits?_____

Comments:_____

Is Minor/ Child taking any prescription / over the counter drugs?

Yes No

Please list each one:_____

Ever been hospitalized? Yes No

Ever had Surgery? Yes No

Has you child ever had any of the following diseases or medical problems? (Please circle option that applies)

Asthma	Yes	No	Allergies	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No
HIV/AIDS	Yes	No	Hemophilia	Yes	No
Diabetes	Yes	No	Rheumatic Fever	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No
Thyroid Disease	Yes	No	Sinus Problems	Yes	No

Abnormal Bleeding Yes No

Drug/Alcohol Abuse Yes No

Handicaps / Disabilities Yes No

Congenital Heart Defect Yes No

Please explain any medical problems (including Allergies) that your child has: _____

_____

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit? _____

Previous Dentist: _____

Child's Physician:_____

Phone Number:(_____)_____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Suck Thumb/ Fingers? Yes No

Suck/Bite Lips? Yes No

Bite/Chew Nails? Yes No

Chew Hard Objects? (Pencils, etc.) Yes No

Grind Teeth? Yes No

Clench Jaws? Yes No

Dentist's Review

_____

_____

_____

Date:___/___/___ **Signature:**_____

Health History Update

Comments:_____

_____

_____

Date:___/___/___ Dr. Signature:_____

Comments:_____

_____

_____

Date:___/___/___ Dr. Signature:_____

Comments:_____

_____

_____

Date:___/___/___ Dr. Signature:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services for my minor/child.

_____ _____

Signature Date