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

*Name(first)*_____ *(M)*___ *(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 so, which school?*_____

If under 18 or full time student ONLY Responsibility Party Information

*Name(Mother/Father)*_____ *Social Security #*_____

*Address*_____

*Phone*_____ *Birthdate*_____

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

Dental Insurance Information

*Employee's Name*_____ *Social Security #*_____

*Employer Name&Address*_____ *Phone*_____

*Insurance Co.*_____ *Group #*_____

*Insurance Co. Address*_____ *Phone #*_____

Are you covered under another insurance plan? ___ *YES* ___ *NO*
*If yes, name of 2nd insurance company*_____ *Group #*_____

*Name of employee for 2nd insurance company*_____
*Social Security # for 2nd insurance company*_____

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*_____

Medical History

Your current physical health is: ___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, for 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 Nursing?__Y__N

Have you ever had any of the following diseases or medical problems?

Y N	*Abnormal Bleeding*	*Y N*	*Hemphilia*
Y N	*Alcohol/Drug Abuse*	*Y N*	*Hepatitis*
Y N	*Anemia*	*Y N*	*Herpes/Fever Blisters*
Y N	*Angina*	*Y N*	*High Blood Pressure*
Y N	*Arthritis*	*Y N*	*HIV +/AIDS*
Y N	*Artificial Bones/Joints/Valves*	*Y N*	*Hospitalized for any reason*
Y N	*Asthma*	*Y N*	*Kidney Problems*
Y N	*Blood Transfusion*	*Y N*	*Liver Disease*
Y N	*Caner/Chemo/Radiation*	*Y N*	*Low Blood Pressure*
Y N	*Congenital Heart Defect*	*Y N*	*Mitral Valve Prolaspe*
Y N	*Diabetes*	*Y N*	*Pacemaker*
Y N	*Difficulty Breathing*	*Y N*	*Pre-medication*
Y N	*Emphysema*	*Y N*	*Psychiatric Problems*
Y N	*Epilepsy*	*Y N*	*Rhematic/Scarlet Fever*
Y N	*Fainting Spells*	*Y N*	*Seizures*
Y N	*Frequent Headaches*	*Y N*	*Shingles*
Y N	*Glaucoma*	*Y N*	*Sickle Cell Disease*
Y N	*Hay Fever*	*Y N*	*Sinus Problems*
Y N	*Heart Attack/Stroke*	*Y N*	*Thyroid Problems*
Y N	*Heart Surgery/Murmur*	*Y N*	*Tuberculosis (TB)*

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 taking bisphosphonate (i.e. aredia, zometa, fosamax, sctonel, boniva, ostac, skelid, didronel, etc.) __Y __N If so, what? _____

Are you Allergic to any of the following?

Y N	*Aspirin*	*Y N*	*Erythromycin*	*Y N*	*Tetracycline*
Y N	*Codeine*	*Y N*	*Latex*	*Y N*	*Other: _____*
Y N	*Dental Anesthetics*	*Y N*	*Penicillin*		_____

Reason for your visit_____
To the best of my knowledge the questions on this form have been accurately answered.

Signature _____ Date_____

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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 #

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

Mother Stepmother Guardian

Name:_____

E-Mail:_____

Home Phone #:_____

Work Phone #:_____

Social Security#:_____

Employer:_____

Occupation:_____

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

Father Stepfather Guardian

Name:_____

E-Mail:_____

Home Phone #:_____

Work Phone #:_____

Social Security#:_____

Employer:_____

Occupation:_____

Who is responsible for making appointments?

Name:_____

E-mail:_____

Relationship:_____

Home Phone #:_____

Work Phone #:_____

Best Time to Call: (Time)_____ Days_____

Parent's Marital Status

Single Married

Divorced Widowed Separated

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: _____

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

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:_____