dr. DDS OF MONTCLAIR d'amore russo DENTAL DESIGN STUDIO

WELCOME

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ S.S.#: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____

Emergency Contact: _____ Emergency Phone #: _____

RESPONSIBLE PARTY

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____

Email: _____

INSURANCE INFORMATION

Insurance Company: _____

Subscriber's Name: _____

Subscriber's Birthdate: _____

Subscriber's ID #: _____

Subscriber's Group #: _____

Employer's Name: _____

Employer's Phone #: _____

Dr. Joseph C. D'Amore, DDS | Dr. Michela Russo, DDS
100 Grove St. Suite 3. Montclair, NJ 07042
drddssmiles@gmail.com P: (973) 233-1161 F: (973) 233-1164
www.drdentaldesignstudio.com

dr. DDS OF MONTCLAIR d'amore russo DENTAL DESIGN STUDIO

MEDICAL HISTORY

Physician's Name: _____ Phone #: _____

Physician's Address: _____

1. Are you currently taken any medications/supplements? O YES O NO

Please list: _____

_____

_____

2. Do you smoke or use tobacco in any other form? O YES O NO

3. Have you ever taken Fosamax or any other bisphosphate? O YES O NO

4. Have you ever been told that you snore or hold your breath while sleeping or wake up gasping for breath? O YES O NO

FOR WOMEN:

5. Are you using a prescribed method of birth control? O YES O NO

6. Are you pregnant? O YES O NO

7. Are you nursing? O YES O NO

Please circle any of the following diseases or medical problems that you have or had:

Abnormal Bleeding	Fainting Spells	Liver Disease	Thyroid
Alcohol/Drug Abuse	Frequent Headaches	Low Blood Pressure	Tuberculosis
Anemia	Glaucoma	Lupus	Ulcers
Arthritis	Hay Fever	Mitral Valve Prolapse	Venereal Disease
Artificial Bones/Joints/Valves	Heart Attack	Osteoporosis	
Asthma	Heart Murmur	Pacemaker	
Blood Transfusion	Heart Surgery	Psychiatric Treatment	
Cancer/Chemotherapy	Hemophilia	Radiation Treatments	
Colitis	Hepatitis	Rheumatic/Scarlet Fever	
Congenital Heart Defect	Herpes/Fever Blisters	Seizures	
Diabetes	High Blood Pressure	Shingles	
Difficulty Breathing	HIV/AIDS	Sickle Cell Disease/Traits	
Emphysema	Hospitalizations	Sinus Problems	
Epilepsy	Kidney Problems	Stroke	

Dr. Joseph C. D'Amore, DDS | Dr. Michela Russo, DDS
100 Grove St. Suite 3. Montclair, NJ 07042
drddssmiles@gmail.com P: (973) 233-1161 F: (973) 233-1164
www.drdentaldesignstudio.com

dr. DDS OF MONTCLAIR d'amore russo DENTAL DESIGN STUDIO

MEDICAL HISTORY CONTINUED

Please list any serious medical condition(s) that you have ever had:

_____

_____

Please circle any of the following drugs/materials you are allergic to:

Aspirin	Codeine	Dental	Anesthetics	Erythromycin
Tetracycline	Latex	Penicillin	Other	

Please list any other drugs/materials that you are allergic to:

_____

_____

DENTAL HISTORY

1. Why have you come to the dentist today?

_____

_____

2. Do you require antibiotics before dental treatment?	O YES	O NO
3. Are you currently in pain?	O YES	O NO
4. Do you like your smile?	O YES	O NO
5. Have you ever had a serious/difficult problem associated with any previous dental work?		
6. Do you have fears about going to the dentist?	O YES	O NO
7. Have you ever had gum treatment?	O YES	O NO
8. Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?	O YES	O NO
9. Do your gums ever bleed?	O YES	O NO
10. Are your teeth sensitive to heat, cold or anything else?	O YES	O NO
11. Have you lost any teeth?	O YES	O NO

12. How many times a week do you floss? _____

13. How many times a day you brush? _____

14. How often do you change your toothbrush? _____

15. Type of bristles? SOFT MEDIUM HARD

Dr. Joseph C. D'Amore, DDS | Dr. Michela Russo, DDS
100 Grove St. Suite 3. Montclair, NJ 07042
drddssmiles@gmail.com P: (973) 233-1161 F: (973) 233-1164
www.drdentaldesignstudio.com

dr. DDS OF MONTCLAIR d'amore russo DENTAL DESIGN STUDIO

ACKNOWLEDGEMENT

I understand the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Patient/Parent/Guardian Name (Print) Date

_____ _____

Patient/Parent/Guardian (Signature) Date

Payment is due in full at the time of treatment, unless prior arrangements have been approved. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the dental insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

_____ _____

Patient/Parent/Guardian Name (Print) Date

_____ _____

Patient/Parent/Guardian (Signature) Date

Dr. Joseph C. D'Amore, DDS | Dr. Michela Russo, DDS
100 Grove St. Suite 3. Montclair, NJ 07042
drddssmiles@gmail.com P: (973) 233-1161 F: (973) 233-1164
www.drdentaldesignstudio.com