



# Welcome To Our Office!

*Thank you for trusting us with your dental care.  
We promise to do our best to provide you with the finest care available.  
If you have any questions please do not hesitate to call us.*

## PATIENT INFORMATION

Patient \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced  
 Patient SS# \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 Employer Phone \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 \_\_\_\_\_

## DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_  
 \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Is patient covered by additional insurance?  Yes  No  
 Subscriber's Name \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Drs. Bonar and Basso all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_

## CONTACT INFORMATION

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_ Cell \_\_\_\_\_  
 Spouse's Work \_\_\_\_\_ Ext \_\_\_\_\_ Spouse's Cell \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_  
 IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

*Please Complete Both Sides*

# HEALTH HISTORY

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_ Date of last visit \_\_\_\_\_

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Women:			
		Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Due date _____			
		Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## MEDICATIONS

List medications you are currently taking: \_\_\_\_\_  
 Have you, are you or will you be taking bisphosphonates medication (alendronate-Fosamax, risedronate-Actonel or IV drugs - Aredia or Zometa) for osteoporosis, Paget's disease or for any other reason?  Yes  No  
 Have you ever taken Fen-Phen?  Yes  No      Have you ever taken Redux?  Yes  No  
 Pharmacy Name \_\_\_\_\_ Pharmacy Phone Number \_\_\_\_\_

## ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Other _____
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin	_____
	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa	_____

## DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_  
 Former Dentist \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date of last dental care \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_  
 Check (✓) if you have had problems with any of the following:  
 Bad Breath       Grinding teeth       Sensitivity to hot  
 Bleeding Gums       Loose teeth or broken fillings       Sensitivity to sweets  
 Clicking or popping jaw       Periodontal treatment       Sensitivity when biting  
 Food collection between teeth       Sensitivity to cold       Sores or growths in your mouth  
 How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

DATE	PATIENT'S/PARENT'S SIGNATURE	P/BP	DOCTOR'S SIGNATURE