Bellamy Dental, Dr. Vincent D. Greco & Dr. Josie Porzio

MEDICAL AND DENTAL HISTORY

Name: _____ Age:_____ Driver's License number: _____

Date: _____ Birth Date (m/d/y): _____ Gender:_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Business: _____

E-Mail address:_____

Place of Employment: _____ Position/Title: _____

IF MARRIED: (for contact information)

Spouse's Name: _____

Place of Employment: _____ Spouse Business Phone:_____

Emergency Contact: _____ Phone: _____

Relationship:_____

DENTAL INSURANCE INFORMATION:

Policy Holder: _____ Date of Birth:_____

Insurance Company: _____ Policy #:_____ ID#:_____

Patient (Guardian) Signature: _____

Who may we thank for your referral? _____

CONFIDENTIAL MEDICAL HISTORY

1. Date of last physical examination:	2. Family Physician:
3. Are you currently under the care of a physician?	Yes No If yes please specify:
4. Are you presently taking any pills, drugs or medication?	Yes No If yes please specify:
5. Have you taken any prolonged medication in the past?	Yes No If yes please specify:
6. Do you have heart disease or a murmur?	Yes No
7. Do you become breathless easily?	Yes No
8. Have you had abnormal bleeding?	Yes No
9. Have you taken cortisone or steroids?	Yes No
10. Have you any allergies?	Yes No If yes please specify:
11. Have you allergies to any drugs or medicines?	Yes No i.e. Penicillin. Please specify:

12. Have you ever been hospitalized and was surgery performed?	Yes No If yes please specify:
13. Are your ankles often swollen?	Yes No
14. Have you gained or lost excessive weight recently?	Yes No
15. Have you ever had radiation or therapy?	Yes No

16. Do you suffer from any of the following: (Please circle)

Asthma	High Blood Pressure	Anemia	Chest Pain	Sinus Problems
Herpes	Low Blood Pressure	Arthritis	Blood Disorders	Thyroid Problems
Cancer	Nervous Problem	Epilepsy	Heart Trouble	Tuberculosis
Ulcers	HIV Positive/AIDS	Diabetes	Venereal Disease	Hepatitis
Stroke	Kidney Trouble	Liver Trouble	Scarlett Fever	Fainting Spells

17. Are you currently in good health?	Yes No
18. Is there anything else you think you should tell me?	Yes No If yes please specify:

CONFIDENTIAL DENTAL HISTORY

1. Are you having any discomfort at this time?	Yes No If yes please specify:
2.Have you been under regular care of a dentist?	Yes No
3. How long since your last dental visit?	
4. What was done at that time?	
5. What is your chief complaint about your teeth?	
6. How would you like us to help you?	
7. Do your gums feel tender or swollen?	Yes No
8. Have you ever been given local (freezing) anesthetic?	Yes No If yes, any complications?
9. Are you aware of any lump or swelling in your mouth?	Yes No
10. Are you satisfied with the appearance of your teeth?	Yes No
11. Are you anxious to keep your natural teeth?	Yes No
12. Are you tense during dental visits?	Yes No

13. Do you currently experience any of the following: (Please circle)

Loose Teeth	Bleeding Gums	Sore Gums	Spaced or Crooked Teeth	Gagging
Sensitive Teeth	Bad Breath	Popping Jaw Joints	Unsatisfactory Dentures	Headache
Clenching/Grinding	Neck Pain	Missing Teeth	Unexplained Nosebleeds	Earache

14. Have you had serious trouble associated with previous dental treatment?	Yes No If yes please specify:
15. Is there anything in your medical or dental history that we have not specifically asked about that we should be made aware of?	If so, please explain.
16. Are you pregnant?	Yes No

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable and that I will assume responsibility for all fees associated with those procedures. I am aware that payment is due as procedures are performed.
I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such case, I will be informed of the need for additional treatment and its fee.

- I have been advised of the office's privacy policy.
- I have provided accurate dental and medical history and have not knowingly omitted any information. Should there be any changes in my health status or any other information provided I will advise this dental office.

Patient (Guardian) Signature: _____ Date: _____

Reviewed by treating dentist:_____ Date: _____