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WELCOME TO THE OFFICE OF DR. PICCHIONI
MEMBER OF THE AMERICAN DENTAL ASSOCIATION

NAME(first)________________________________(mi)____(last)______________________________

ADDRESS ____

CITY_________________________STATE _____ZIP___________DATE OF BIRTH ______________

PHONE__________________________CELL____________________EMAIL_____________________

SOCIAL SECURITY #___________________________ ___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_____________________________CITY__________________STATE_____ZIP__________

DATE OF BIRTH _____________________PHONE______________________CELL________________

EMPLOYER___________________________OCCUPATION_______________WORK#_______________

Dental Insurance Information

EMPLOYEE'S NAME__________________________S.S#__________________DOB_______________

EMPLOYER____PHONE_____________________

INSURANCE CARRIER______________________________ID#____________________GROUP__________

INSURANCE ADDRESS____PHONE_______________

Are you covered under another dental plan? ____YES ___NO

IF yes, name of 2nd insurance carrier/address ______________________________________

Name of employee for second insurance____

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.

_______________________________ _______________________________

Signature (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

Are you currently under the care of a physician? ___Yes ___No Reason ____________________________

Name of physician ____

Do you smoke or use tobacco in any other forms? ___Yes ___No If yes, how long___________________

Are you taking any prescriptions/over the counter drugs? ___Yes ___No

Please list each one:____

____

Are you taking birth control pills?___Yes ___No Are you pregnant? ___Yes ___No Are you Nursing?___Yes___No

Do you need to pre-medicate before your dental visits? ___Yes ___No Reason_____________________________

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

Y N	Abnormal Bleeding	Y N	Hemophilia
Y N	Alcohol/Drug Abuse	Y N	Hepatitis
Y N	Anemia	Y N	Herpes/Fever Blisters
Y N	Angina/Chest pain	Y N	High or Low Blood Pressure
Y N	Anxiety/Nervous	Y N	HIV+/AIDS
Y N	Arthritis/Rheumatism	Y N	Hospitalized for any reason
Y N	Artificial Bones/Joints/Valves	Y N	Kidney Problems
Y N	Asthma	Y N	Liver Disease
Y N	Blood Transfusion	Y N	Mitral Valve Prolapse
Y N	Cancer/chemotherapy/radiation	Y N	Osteonecrosis/Jaw
Y N	Colitis	Y N	Osteoporosis/Bone Disease
Y N	Congenital Heart Defect	Y N	Pacemaker
Y N	COVID-19	Y N	Psychiatric Problems
Y N	Diabetes	Y N	Rheumatic/Scarlet Fever
Y N	Difficulty Breathing	Y N	Shingles
Y N	Emphysema	Y N	Sickle Cell Disease
Y N	Epilepsy/Seizures	Y N	Snoring/Sleep Apnea
Y N	Fainting Spells	Y N	Stroke
Y N	Glaucoma	Y N	Thyroid Problems
Y N	Hay Fever/Sinus Problems	Y N	Tuberculosis (TB)
Y N	Heart Attack	Y N	Ulcers
Y N	Heart Murmur	Y N	Venereal Disease
Y N	Heart Surgery		

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

Are you taking any blood thinners? (i.e. aspirin, coumadin) ___Yes ___No If so, what?____________________

Are you **ALLERGIC** to any of the following or any other medications?______________________________

Y N	Aspirin/Ibuprofen/Tylenol	Y N	Erythromycin	Y N	Sulfa
Y N	Codeine/Valium	Y N	Latex/Metals	Y N	Tetracycline
Y N	Anesthetics/Local medications/ Substances	Y N	Penicillin/Amoxicillin	Y N	Other_________

Reason for your visit today____

To the best of my knowledge the questions on this form have been accurately answered and I consent to the dental care reviewed/diagnosed.

Signature_____________________________________ **Date**____________________________