CHRISTINE Tenaglia DDS
IT ALL BEGINS WITH YOUR SMILE

Patient Health History

Help Us To Understand You

Name: Mr. Mrs. Miss Doctor
Last_____ First_____ MI_____Preferred Name_____

Male or Female (Circle one) Single Married Minor
Birth Date_____SS#_____DL#_____
Address _____ (circle one)
E-mail Address _____**Best way to confirm: Call Email Text**
Home #_____Work #_____
Cellular #_____Other #_____
In the event of an emergency, who should be contact?
Name_____Relationship_____Phone #_____

Employer

Employers Name_____
Address_____
City_____State_____Zip Code_____

Dental Insurance

Primary Dental Insurance
Name of Insured_____Relationship to Patient_____
SS#_____Date of Birth_____
Employer_____Insurance Company_____
Group #_____Insurance Address_____

Secondary Dental Insurance
Name of Insured_____Relationship to patient_____
SS#_____Date of Birth_____
Employer_____Insurance Company_____
Group #_____Insurance Address_____

Do you or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	❒	❒	Cancer	❒	❒	Sexual Diseases	❒	❒
Heart Murmur	❒	❒	Leukemia	❒	❒	Respiratory Problems	❒	❒
Cardiac Pacemaker	❒	❒	Radiation Therapy	❒	❒	Asthma	❒	❒
Heart Surgery	❒	❒	Hepatitis (type_____)	❒	❒	Sinus Trouble	❒	❒
Heart Disease	❒	❒	Liver Disease	❒	❒	Allergies/Hayfever	❒	❒
Prosthesis Heart Valve	❒	❒	Kidney Disease	❒	❒	Thyroid Condition	❒	❒
Mital Valve Prolapsed	❒	❒	Anemia	❒	❒	Stomach Ulcers	❒	❒
High Blood Pressure	❒	❒	Epilepsy/Convulsions	❒	❒	Recent Weight Loss	❒	❒
Low Blood Pressure	❒	❒	Fainting/Seizures	❒	❒	Bleeding Problem	❒	❒
Heart Attack	❒	❒	Tuberculosis	❒	❒	Substance Abuse Problem	❒	❒
Surgical Pins/Plates	❒	❒	Glaucoma	❒	❒	Arthritis/Rheumatism	❒	❒
Artificial Joints	❒	❒	Emphysema	❒	❒			
Stroke	❒	❒	AIDS/ARC/HIV	❒	❒			
Diabetes	❒	❒						

Allergies

Are you allergic to or have any reactions to the following?

	Yes	No		Yes	No		Yes	No
Local anesthetic	❒	❒	Aspirin	❒	❒	Other_____		
Penicillin or antibiotics	❒	❒	Latex	❒	❒			
Sulfa drugs	❒	❒	Codeine	❒	❒			

	Yes	No	
Are you under medical/dental treatment now?		❒	❒
Do you use tobacco? (Smoking or chew)	❒	❒	
Have you been advised to take medication prior to dental appointments?	❒	❒	

Are you currently taking any medication? Prescription or over the counter?

1_____ 2_____ 3_____ 4_____

Physician_____ Phone_____

Address_____ Medical Insurance_____

_____ _____ _____ _____

How did you hear about us (circle one)?

Location Internet Personal Referral_____

	Yes	No		Yes	No
Do you feel nervous about dental treatment?	❒	❒	Do your gums bleed?	❒	❒
Have you ever had a bad dental experience?	❒	❒	Are your teeth sensitive?	❒	❒
Do you have sores/lumps in your mouth?	❒	❒	Do you like your smile?	❒	❒
Do you want to keep your remaining teeth?	❒	❒	Do you clench/grind your teeth	❒	❒
Have you had any head, neck, or jaw injuries?	❒	❒	Do you have frequent headaches?	❒	❒
Do you have popping, clicking, pain in your jaw?	❒	❒			
Do you have difficulty opening, closing, or chewing?	❒	❒			

Smile Analysis

How would you rank your smile? (circle one)

Unpleasant 1 2 3 4 5 6 7 8 9 10 Beautiful

Would you like information on Bleaching, porcelain crowns or white fillings? Yes No

I, the undersigned, understand that my dependent or I have completed the health questions and the preceding information is true and correct. This office will not be held responsible for any problems arising out of important information not disclosed.

I understand the provider's charge may exceed the "reasonable and customary" charge or may not be a covered benefit under my present insurance plan. I agree to accept responsibility for payment of any remaining or full amounts.

I hereby authorize Dr. Christine Tenaglia to release all information necessary to secure the payment benefits and I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Date Relationship