Robert J. Moretta, D.D.S.

Thank you for choosing our office for your dental treatment. In order that we may be more effective in meeting your needs, please complete this entire form in full.

Name____Age_________Spouse's Name_______________

Residence Address_____________________________City_________________________Zip___________

Mailing Address_______________________________City_________________________Zip___________

Residence Phone__________________Cell Phone__________________E Mail_____________________

Driver's License No.________________Social Security No.______________Birth Date_________________

Married______Single______Divorced______Separated______Widowed______

Employed by____Occupation____________________

If Self-employed, name of business____

Business Address____Bus. Phone__________________

Spouse Employed by_______________________________________Occupation_____________________

If Self-employed, name of business_____________________________Bus. Phone__________________

Name of nearest relative not living with you______________________________Relation________________

Address____Phone_______________________

Name of Physician_______________________City____________________Phone____________________

Former Dentist_________________________City____________________Phone_____________________

Purpose of Appointment____

Is this visit for emergency dental care?____

Whom may we thank for referring you?____

Person responsible for this account___________________________________Relation________________

Address____Phone_________________

Insurance Company Name________________________________Group No.________________________

Social Security Number of Insured_______________________Insured Birth Date______________________

Secondary Insurance Company Name____________________________Group No.___________________

Social Security Number of Insured_______________________Insured Birth Date______________________

Comments____

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Please complete other side

Medical History

1. Are you under medical treatment now?..............yes no
Explain____
2. Have you had a joint or heart valve replaced?...yes no
3. Are you allergic to any of the following?
Local anesthetics (e.g. Novocaine, etc)............yes no
Aspirin...yes no
Codeine..yes no
Penicillin...yes no
Erythromycin..yes no
Tetracycline or other antibiotics........................yes no
Other____
4. Do you use tobacco?..yes no
5. Do you take medication for osteoporosis?………yes no

6. Do you use recreational drugs (ie. cocaine)?....yes no
7. Are you taking any medications including non-prescription medicine?...............................yes no
If yes, what medication(s) are you taking_____________
____
____
8. Women only:
a) Are you pregnant or think you may be?.....yes no
b) Are you taking birth control pills?....….......yes no

9. Do you have or have you had any of the following? (Please check known conditions)

___High Blood Pressure
___Heart Disease
___Rheumatic Fever
___Diabetes
___Hepatitis/Jaundice
___Mitro Valve Prolapse (MVP)
___Heart Attack
___Stroke
___Cancer
___Heart Murmur
___Liver Disease
___Asthma
___Epilepsy/Convulsions
___AIDS or HIV infection
___Kidney Disease
___Tuberculosis
___Sexual Transmitted Disease
___Herpes
___Allergies/Hay Fever
___Glaucoma
___Arthritis
___Sinus Trouble
___Nervous Disorders
___Dry Mouth
___Difficulty with Swallowing
___Excessive Bleeding
___Tumors/Growths
___Angina
___Osteoporosis
___Other________________________

Dental History

1. How long has it been since your last complete series of oral X-rays(not check up X-rays)?__________________
2. How long since your last dental treatment?_______________________
3. Have you ever had local anesthetic (novocaine)...…..........yes no
4. Have you ever had any serious trouble with any previous dental treatment?..............................…...........yes no
5. Have you ever been told that you have gum disease (pyorrhea)?..…...........yes no
6. Do you clinch or grind your teeth?..yes no
7. Do you snore?...yes no
8. Does dental treatment make you nervous..........yes no If yes, _____slightly_____moderate_____extremely
9. Would you desire to be pre-sedated or use Nitrous oxide?..…........yes no
10. Is it important to you to keep your natural teeth?...….......yes no
11. If you could wave a magic wand and change anything about your smile, what would it be? _______________________
____
12. If there was a simple, inexpensive way to whiten your teeth, would you be interested?___________________________
13. Why did you leave your last dentist?____
14. What did you like most about any dentist you=ve ever seen?____
15. What did you like least about any dentist you=ve ever seen?____

Consent

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have changes in my health, or if my medicines change, I will inform the doctor. I authorize the doctor to take radiographs, study models or any other diagnostics aids deemed appropriate in order to make a thorough diagnosis. I also authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated after proper explanation, alternatives and consequences have been given to me.

Signature____**Date**_________________________