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?_____

How did you hear about our office? _____

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_____

_____

_____

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?
Are you allergic to Latex?.....yes no
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? For example, Fosamax or Boniva…….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	___Liver Disease	___Arthritis
___Heart Disease	___Asthma	___Sinus Trouble
___Rheumatic Fever	___Epilepsy/Convulsions	___Nervous Disorders
___Diabetes	___AIDS or HIV infection	___Dry Mouth
___Hepatitis/Jaundice	___Kidney Disease	___Difficulty with Swallowing
___Mitro Valve Prolapse (MVP)	___Tuberculosis	___Excessive Bleeding
___Heart Attack	___Sexual Transmitted Disease	___Tumors/Growths
___Stroke	___Herpes	___Angina
___Cancer	___Allergies/Hay Fever	___Osteoporosis
___Heart Murmur	___Glaucoma	___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 docto r 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**_____