

Welcome to the Practice

We are pleased to welcome you to the office of Dr. John J. Tortora, DDS. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Social Security # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced Partnership

Employer _____ Business Phone _____ Occupation _____

Business Address _____

Emergency Contact _____ Phone _____ Relationship _____

Whom may we thank for referring you to the office? _____ Reason for choosing us? _____

How did you hear about the office? Internet Patient Holistic Insurance Other _____

Person Responsible for Account _____ Relationship to patient _____
Last Name *First Name* *Initial*

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber Name _____ Member ID _____
Last Name *First Name* *Initial*

Relationship to patient _____ Birthdate _____ Sex M F Social Security # _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Employer _____ Business Phone _____ Extension _____

Occupation _____ Business Address _____

Insurance Company _____ Insurance Phone _____

Insurance Address _____ Group # _____

Insurance Phone _____ Other dependents on plan _____

SECONDARY DENTAL INSURANCE INFORMATION

Is the patient covered by additional dental insurance? Yes No

Subscriber Name _____ Member ID _____

Last Name

First Name

Initial

Relationship to patient _____ Birthdate _____ Sex M F Social Security # _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Employer _____ Business Phone _____ Extension _____

Occupation _____ Business Address _____

Insurance Company _____ Insurance Phone _____

Insurance Address _____ Group # _____

Insurance Phone _____ Other dependents on plan _____

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort? Yes No

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____ Date of last visit _____

Date of Last X-Rays? _____ Do you want us to obtain a copy of these X-rays for you? Yes No

How often do you brush? _____ Floss? _____ Use Waterpik®? _____

How do you feel about the appearance of your teeth? _____ Color? _____

Have you ever had an adverse reaction during or in conjunction with a medical or dental procedure? Yes No

If yes, please explain: _____

Other information about your dental health or previous treatment/experiences that you would like us to be aware of? Yes No

Explain: _____

MEDICAL HISTORY

Primary Care Physicians Name: _____ Phone _____ Last Visit: _____

Have you ever had serious operation or illness? Yes No Hospitalizations in the past 5 years? Yes No

Describe: _____ Do you require pre-medication for dental procedures? Yes No

Currently under physicians care? Yes No If **yes**, list all MD's and Chiropractors that you are under the care of: _____

Have you ever had a blood transfusion? Yes No If yes, approx. date _____

Women: Are you pregnant? Yes No Trying to conceive? Yes No Nursing? Yes No On birth control pills? Yes No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

NONE

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV POSITIVE | <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> NEUROLOGIC PROBLEM |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CORTISONE TREATMENTS | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> COUGH, PERSISTENT | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RADIATION/CHEMO |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DEMENTIA | <input type="checkbox"/> HEPATITIS, WHICH? ___ | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HERPES | <input type="checkbox"/> PACEMAKER/DEFIBRILLATOR |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> HPV | <input type="checkbox"/> SWELLING OF FEET/ANKLE |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> EYE PROBLEMS | <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> THYROID CONDITION |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> TOBACCO HABIT |
| <input type="checkbox"/> CANCER/MALIGNANCY | <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> LYMES DISEASE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CHEMICAL/ALCOHOL DEPENDENCY | <input type="checkbox"/> RAPID OR IRREGULAR HEART BEAT | <input type="checkbox"/> METHOTREXATE | <input type="checkbox"/> ULCERS/COLITIS |
| | | <input type="checkbox"/> NECK PROBLEMS | <input type="checkbox"/> OTHER - PLEASE LIST: |

ALLERGIES/ALLERGIC REACTIONS (CHECK ALL THAT APPLY)

NONE

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE | <input type="checkbox"/> SLEEPING PILLS |
| <input type="checkbox"/> ANESTHETIC - LOCAL | <input type="checkbox"/> FOOD | <input type="checkbox"/> METAL SENSITIVITY | <input type="checkbox"/> SULFA DRUGS |
| <input type="checkbox"/> BARBITURATES | <input type="checkbox"/> LATEX | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN |
| | <input type="checkbox"/> OTHER: _____ | <input type="checkbox"/> OTHER ANTIBIOTICS: _____ | |

MEDICATION INFORMATION

NONE

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> BLOOD PRESSURE |
| <input type="checkbox"/> BLOOD THINNERS | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS | <input type="checkbox"/> HEART MEDICATION |
| <input type="checkbox"/> INSULIN | <input type="checkbox"/> NITROGLYCERIN | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> RECREATIONAL DRUGS | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS | <input type="checkbox"/> DIABETIC |
| <input type="checkbox"/> OTC DRUGS/ MEDICATIONS (PLEASE LIST BELOW) | <input type="checkbox"/> OTHER (PLEASE LIST BELOW) | | |

DRUG NAME	DOSAGE	REASON PRESCRIBED

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Print Name: _____ Signature: _____

Relationship to patient: _____ Date: _____