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

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

ALLERGIES/ALLERGIC REACTIONS (CHECK ALL THAT APPLY)

☐ NONE

- ☐ ASPIRIN
- ☐ ANESTHETIC – LOCAL
- ☐ BARBITURATES
- ☐ CODEINE
- ☐ FOOD
- ☐ LATEX
- ☐ LACTOSE INTOLERANCE
- ☐ METAL SENSITIVITY
- ☐ NITROUS OXIDE SEDATION
- ☐ OTHER: _____
- ☐ SLEEPING PILLS
- ☐ SULFA DRUGS
- ☐ PENICILLIN
- ☐ OTHER ANTIBIOTICS: _____

MEDICATION INFORMATION

☐ NONE

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

- ☐ ANTIBIOTICS/SULFA DRUGS
- ☐ ANTIHISTAMINES/ALLERGY
- ☐ BLOOD PRESSURE
- ☐ BLOOD THINNER
- ☐ CANCER/CHEMO MEDICATIONS
- ☐ CHOLESTEROL MEDICATIONS
- ☐ CORTISONE/ STEROIDS
- ☐ DAILY ASPIRIN
- ☐ DIABETIC
- ☐ HEART MEDICATION
- ☐ INSULIN
- ☐ METHOTREXATE
- ☐ NITROGLYCERIN
- ☐ ORAL CONTRACEPTIVES
- ☐ OSTEOPOROSIS
- ☐ OTC DRUGS/ MEDICATIONS (PLEASE LIST BELOW)
- ☐ OTHER (PLEASE LIST BELOW)
- ☐ RECREATIONAL DRUGS
- ☐ THYROID MEDICATIONS
- ☐ TRANQUILIZERS

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: _____

SUBMIT