Arciuolo Family Dentistry

Dr. Robert A. Arciuolo Jr. DMD
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Dental History

Date: _____

Reason for today's visit_____

Former Dentist_____ Why did you leave_____

Date of last exam_____ Date of last X-rays_____

How often do you brush? _____ How often do you floss? _____

Are you happy with your smile? Yes__ No___ What would you change about it? _____

_____

Check any of the conditions that apply to you:

- ☐ Grinding/clenching your teeth
- ☐ Bad Breath
- ☐ Sensitivity:cold/hot to foods/liquid
- ☐ Loose teeth
- ☐ Bleeding gums
- ☐ Sensitivity: sweets/sour foods
- ☐ Broken fillings
- ☐ Clicking/popping jaw
- ☐ Mouth sores
- ☐ Food collection between teeth
- ☐ Sensitivity when biting/chewing foods

Medical History:

Physician: _____ Address: _____Phone#:_____

Date of last visit_____ Have you been hospitalized? _____

Do you have any medication allergies? __yes __No If yes list_____

List Current medication_____ _____

_____

Check any conditions that apply to you:

- ☐ AIDS
- ☐ Cancer
- ☐ Hemophilia
- ☐ Jaw pain
- ☐ Radiation treatment
- ☐ Headache
- ☐ Anemia
- ☐ Chemotherapy
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Stroke
- ☐ skin rash
- ☐ Arthritis
- ☐ Cough
- ☐ High Blood pressure
- ☐ Thyroid problem
- ☐ Swelling
- ☐ Artificial joints
- ☐ Diabetes
- ☐ Jaw pain
- ☐ Liver disease
- ☐ Tuberculosis
- ☐ Tobacco habit
- ☐ Asthma
- ☐ Glaucoma
- ☐ Kidney disease
- ☐ Pacemaker
- ☐ Chemical Dependency
- ☐ Ulcer
- ☐ Blood disease
- ☐ Heart problems
- ☐ HIV positive
- ☐ Psychiatric care
- ☐ Venereal Disease
- ☐ Epilepsy

Authorizations/Release

I certify that I have read and understand the above information to the best of my knowledge and I have answered these questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize any request of my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

SIGNATURE OF PARENT (or parent of minor) Date