CLAUDE E. SIDI, D.M.D.

COSMETIC AND RESTORATIVE DENTISTRY

PATIENT INFORMATION

Date _____ Home Phone _____ Cell Phone _____ Office Phone _____

PERSONAL INFORMATION

Name _____

Address _____

City _____ Zip _____

Social Security No. _____

Birthdate _____ ☐ Married ☐ Unmarried

Employer _____

Business Address _____

City _____

Position _____

SPOUSE/GUARDIAN INFORMATION

Name _____

Employer _____

Business Address _____

City _____

Business Phone _____ ext. _____

Position _____

Birthdate _____

Whom may we thank for referring you? _____

GENERAL INFORMATION

Convenient appointment time _____

Are you available for appointments on short notice _____

Person to contact for emergency _____

Relationship to patient _____

Their telephone _____

Person responsible for account _____

Relationship to patient _____

Driver's License # _____

Bank _____ Branch _____

If you have dental insurance, the following MUST be completed:

PRIMARY CARRIER

Name of insured _____

Social Security # _____

Insurance carrier name _____

Employer _____

Union or Local # _____

AID or Group # _____

Member # _____

Date employed _____

SECONDARY CARRIER

Name of insured _____

Social Security # _____

Insurance carrier name _____

Employer _____

Union or Local # _____

AID or Group # _____

Member # _____

Date employed _____

I hereby authorize this dental facility to render the necessary dental care. If for any reason I do not have coverage under my dental insurance plan, I understand that I am personally responsible for the value of the services received. I also understand that I am responsible for all payments not covered by my dental insurance company irrespective of any estimates provided to me by this dental office.

_____ _____

Signature of Contract Holder
Parent or Guardian

Date

Medical History

Please answer EACH question

1. Do you have, or have you had any of the following:

- ☐ Anemia
- ☐ Heart Ailments
- ☐ High Blood Pressure
- ☐ Respiratory Disease
- ☐ Tuberculosis
- ☐ Nervous Disorders
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Rheumatic Fever
- ☐ Blood Diseases
- ☐ Hepatitis, Jaundice, or Liver Disease
- ☐ Kidney Disease
- ☐ Tumors or Growths
- ☐ Radiation Treatment of any Kind
- ☐ Allergies
- ☐ Asthma or Hay Fever
- ☐ Fainting Spells or Seizures
- ☐ Sinus Trouble
- ☐ Rheumatism or Arthritis
- ☐ Head injuries
- ☐ Stomach Ulcers
- ☐ Veneral Disease
- ☐ AIDS Virus
- ☐ Epilepsy
- ☐ Stroke

1. Are you in good health? ☐ Yes ☐ No
2. Date of last medical exam _____
3. Do you have any disease, problem or condition you think I should know about? _____
4. Have you ever been hospitalized? ☐ Yes ☐ No
   If so, what was the problem? _____
5. Are you taking any drugs or medication? ☐ Yes ☐ No
   If so, what? _____
6. Do you need to be pre-medicated prior to your dental appointments? ☐ Yes ☐ No
7. Are you sensitive or allergic to any drugs? ☐ Yes ☐ No
   If so, what? _____
8. Have you had heart surgery? ☐ Yes ☐ No
9. Are you now under the care of M.D.? ☐ Yes ☐ No
10. Have you had any serious illness? ☐ Yes ☐ No
11. Blood pressure, if known _____

Physician's name _____

Address _____ Phone _____

Remarks

IS THERE ANY ADDITIONAL MEDICAL OR DENTAL INFORMATION WE MAY NEED TO KNOW BEFORE BEGINNING TREATMENT?

_____

_____

For Women Only

Are you pregnant? ☐ Yes ☐ No If yes, what month? _____

Physician's name _____

Address _____ Phone ( ) _____

Dental History

1. How long since you've been to a dentist? _____
2. How long since your last cleaning? _____
3. Reasons for this visit? _____
4. How often do you floss your teeth? _____
5. Have you ever been treated for periodontal disease? ☐ Yes ☐ No
6. Have you ever had any complications from an extraction? ☐ Yes ☐ No
   If yes, explain _____
7. Have you ever had a popping or clicking near your ear when you chew? ☐ Yes ☐ No
8. Are you prone to frequent headaches? ☐ Yes ☐ No
9. Do you grind your teeth? ☐ Yes ☐ No
10. Do your gums bleed when you brush? ☐ Yes ☐ No
11. Do you have sores, blisters or swelling on your gums, lips or cheeks? ☐ Yes ☐ No
12. Have you ever had orthodontic treatment? ☐ Yes ☐ No
13. Are you happy with your smile? ☐ Yes ☐ No

Previous Dentist _____ City _____ Phone ( ) _____

Consent

Adult: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Date _____

Minor: I, being the parent (or guardian) of the above named minor patient, do hereby authorize the performance of dental services upon this patient and whatever procedures that the judgement of the doctor may dictate in order to carry out treatment procedures as outlined on the treatment plan form. I also authorize and request the adminisatration of such anesthetics and/or sedatives as may be deemed advisable by the doctor.

Relative _____ Date _____