Caring Dentistry of Naples

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

PLEASE LIST MEDICATIONS:_____ _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Do you take or have you taken, Phen-fen or Redux? Yes No If yes, please explain: _____

Are you on a special diet? Yes No If yes, please explain: _____

Do you use controlled substances? Yes No If yes, please explain: _____

Do you use tobacco? Yes No If yes, please explain: _____

Women, Are you:

Pregnant/ Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

AIDS/HIV	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Renal Dialysis	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Rheumatic Fever	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Rheumatism	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Scarlet Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Shingles	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	Hives or Rash	Yes No	Sickle Cell Disease	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hypoglycemia	Yes No	Sinus Trouble	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Irregular Heart Beat	Yes No	Spina Bifida	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Kidney Problems	Yes No	Stomach/Intestinal Disease	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Leukemia	Yes No	Stroke	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Liver Disease	Yes No	Swelling of Limbs	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Low Blood Pressure	Yes No	Thyroid Disease	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Lung Disease	Yes No	Tonsillitis	Yes No
Cancer	Yes No	Glaucoma	Yes No	Mitral Valve Prolapse	Yes No	Tuberculosis	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Cold Sores/ Fever Blisters	Yes No	Heart Murmur	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
		Heart Pace Maker	Yes No	Radiation Treatments	Yes No	Yellow Jaundice	Yes No
Congenital Heart Disorder	Yes No	Heart Trouble/Disease	Yes No	Recent Weight Loss	Yes No		
Convulsions	Yes No						

Do you have, or have you had, any of the following?

Have you ever had any serious illness not listed above? Yes No. If yes, please explain:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____

Caring Dentistry of Naples

Patient Registration

First Name: _____ Last Name: _____ Middle initial:_____

Patient is: Policy Holder Preferred Name: _____

Responsible Party

Patient Information:

First Name: _____Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Home Phone: _____

Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Social Security: _____ Drivers Lic: _____

E-mail: _____

Employment Status: Full Time Part Time Retired

Employer: _____

Address: _____

City, State, Zip: _____

Student Status: Full Time Part Time

Emergency Contact:

Name:_____

Phone #:_____

IF INSURED:

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec.: _____ Insured DOB: _____

Ins. Company: _____

Address:_____ City, State, Zip: _____

CANCELLATION POLICY:

We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $50.00** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged. If you have any questions regarding this policy, please let our office staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

Signature of Patient,Parent, or Legal Guardian:_____