Dr. George Galluzzo, D.M.D.

Dental Health History
(Private & Confidential)

Patient Name _____ (Last) _____ (First) _____ (Initial) Birth Date _____

Dental History

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____ Use "Water-pik"? _____

Click box if you have had problems with any of the following;

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Peridontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

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

Medical History

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations? _____ If yes, pls. describe _____

Have you ever had a blood transfusion? _____ If yes, pls. give approximate dates _____

(Women) Are you Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Click box if you have or have had any of the following;

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- Describe: _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Value Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Medications

List medications you are currently taking: _____

_____

_____

_____

Pharmacy Name _____ Phone _____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _____

Signature

The above infomation is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Dr.GeorgeGalluzzo, D.M.D.

Dental Health History
(Private & Confidential)

Patient Information

Address _____

City _____ State _____ Zip code _____

Phone _____ Social Security _____

Date of Birth _____ Marital Status _____

Email _____

Preffered method of contact? ☐ **Email** ☐ **Phone** ☐ **Mail**

Appointment scheduling? ☐ **Email** ☐ **Phone** ☐ **SMS Text**

Would you like your X-rays available online? (secure cloud-based) ☐ **Yes** ☐ **No**

How were you reffered to us? _____

Would you like to receive our quaterly newsletter? ☐ **Yes** ☐ **No**

Insurance Information

Primary Dental Insurance

Address _____

City _____ State _____ Zip code _____

Phone _____ Group/Policy # _____

Employment Information

Employer Name _____

Address _____

City _____ State _____ Zip code _____

Phone _____

Payment

Please choose form of payment:

☐ **Cash** ☐ **Check** ☐ **Visa/MC** ☐ **Amex** ☐ **Discover** ☐ **Insurance** ☐ **ITEX**

I understand I am responsible for all unpaid balances including reasonable collection costs, attorney fees and late charges and possible interest penalites.

Signature: _____ Date: _____