GARGIULO & GARGIULO, D.D.S., LTD.
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Thank you for selecting our dental healthcare team!
To help us meet your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to assist you.

Patient Information

Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Birth date_____ SS# _____ Wishes to be called _____
e-mail address _____
☐ Male ☐ Female ☐ Minor? ☐ Single ☐ Married
Employer _____ Job Title_____
Home Phone _____ Work Phone _____ Cell _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____ Phone _____ _____
Referred by _____

Responsible Party/Primary Insurance

Person responsible for account: _____ Birth date _____
Relationship to patient _____ SS# _____
E-mail address _____
Address _____
City _____ State_____ Zip _____
Work Phone _____ Home Phone _____ Cell _____
Employer _____ Job Title_____
Date Employed _____ Insurance Company _____
Group # _____ Employee/Policy/Subscriber # _____
Insurance Company Address _____
_____

Additional Insurance

Is patient covered by additional insurance? _____ If so, subscriber name _____
Relationship to patient _____ SS# _____
Address _____
City _____ State _____ Zip _____
Work Phone _____ Home Phone _____ Cell _____
Employer _____ Occupation _____
Date Employed _____ Insurance Company _____
Group # _____ Employee/Policy/Subscriber # _____

Insurance Company Address _____

_____

Dental History

What would you like us to do today?_____

Are you in dental pain today? _____

Previous Dentist _____ City/State _____

Date of last dental care _____ Date of last dental X-Rays _____

Check off any of the following you have or have had:

☐ Bad Breath	☐ Food collecting between teeth	☐ Periodontal Treatment	☐ Sensitivity to sweets
☐ Bleeding Gums	☐ Grinding or clenching teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking/popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to hot	☐ Sores/growths in mouth

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

How do you feel about the appearance of your teeth? _____ _____

Have you ever had an adverse reaction due to a medical or dental procedure? _____

Any other information about your dental health or previous treatment? _____

Health History

Physician's Name _____ Date of last physician visit _____

1. Are you now under the care of a physician? _____ If yes, describe _____

2. Have you ever had a blood transfusion? _____ If yes, approximate date _____

3. Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) _____

4. **Women:** Are you pregnant? If so, give due date _____ Are you nursing? _____

5. Do you smoke? _____

Check off any of the following you have now, or have ever had:

☐ Sinus Problems	☐ High Blood Pressure	☐ Stroke	☐ Jaundice
☐ Tuberculosis	☐ Anemia or Blood Problems	☐ Neurological/Epilepsy	☐ Kidney Problems
☐ Asthma/Hay Fever	☐ Blood Transfusion	☐ Cancer/Malignancies	☐ Gout
☐ Allergies	☐ Excessive Bleeding	☐ Tumors/Growths	☐ Joint/Hip Replace
☐ Sore/Hoarse Throat	☐ Bruise Easily	☐ Chemotherapy	☐ Arthritis
☐ Emphysema	☐ AIDS/HIV+	☐ Radiation Treatment	☐ Latex Sensitivity
☐ Rheumatic Fever	☐ Venereal Disease	☐ Thyroid Condition	☐ Liver Disease
☐ Mitral Valve Prolapse	☐ Headaches	☐ Diabetes	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Convulsions/Epilepsy	☐ Ulcer or Colitis	☐ Jaw Pain
☐ Pacemaker	☐ Psychiatric Treatment	☐ Hepatitis	☐ Shortness of Breath
☐ Heart Murmur	☐ Heart Condition (explain) _____		

List *name* of any medication(s) you are currently taking _____

List any drug allergies you have _____

Authorization and Release

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.

Signature of Patient,
or Legal Representative _____ Date _____