

BEE CAVE DENTAL CENTER
Corinne R. Scalzitti D.M.D., M.A.G.D.

PATIENT INFORMATION:

Name _____
 Last M.I. First

Address: _____
 Street Apt. # City, State, Zip

Phone _____
 Home Work Cell

E-mail _____

Social Security Number: _____ - _____ - _____ Date of Birth _____ Age _____

Drivers Lic. # _____ Sex: M _____ F _____

Married _____ Separated _____ Divorced _____ Single _____ Widowed _____ Minor _____ Partnered _____

Patient Employer _____ Full Time Student at _____

Occupation _____ Business address _____

Spouse's Name _____ Employer _____

Social Security Number: _____ - _____ - _____ Date of Birth _____ Drivers Lic. # _____

How did you hear about our office? _____

Purpose of today's appointment? _____

Previous Dentist? _____ Last dental visit? _____

Where? _____ X-rays? Y _____ N _____
 Date

INSURANCE INFORMATION:

Subscriber Name _____ Relation to the patient: _____

Date of Birth _____ Social Security Number _____ - _____ - _____

Member ID# _____ Group # _____

Insurance Company Name _____ Insurance Phone Number _____

Insurance claim filing address _____

MEDICAL HEALTH HISTORY

The following questions will be considered strictly confidential. Please answer each, and briefly explain "Yes" answers in space provided.

My last physical examination was: _____ Physician's name, city and state _____

My current health status is: Excellent Good Fair Poor

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Are you presently under physician's care? For _____
<input type="checkbox"/>	<input type="checkbox"/>	Women: Are you pregnant? Estimated date of Delivery _____ Birth Control? Yes / No
<input type="checkbox"/>	<input type="checkbox"/>	Have you been hospitalized, for any reason, in the past 5 years? _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any drugs, medicines, or injections? If so, list each one with reason underneath: _____ _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to / reacted adversely to any of the following medications? Circle ANY that apply. Aspirin Darvon Nitrous Oxide Gas Percodan Local Anesthetic (Novacaine) Codeine Erythromycin Valium Penicillin Latex Metals: _____ Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you need to be pre-medicated or have you been advised to take antibiotics prior to dental treatment?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken FenPhen or any other diet drugs?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any complications or problems with previous dental treatment? _____

Circle ANY of the following which you have had or have at present:

- | | | | | |
|--------------------------|--------------------------------|--------------------------------|-----------------------------|-------------------------------------|
| Heart Failure | Heart Surgery | Liver Disease | Sickle Cell Disease | Hay Fever |
| Heart Disease or Attack | Anemia | Yellow Jaundice | Glaucoma | Sinus Trouble |
| Angina Pectoris | Stroke | Blood Transfusion | Chemotherapy | Allergies or Hives |
| High Blood Pressure | Kidney Trouble | Alcohol or Drug Addiction | Cancer or Leukemia | Diabetes I or II |
| Heart Murmur | Ulcers | Hemophilia or Bleeding Problem | Venereal Disease | Thyroid Disease |
| Rheumatic Fever | A.I.D.S. | Fever Blisters | (Syphilis, Gonorrhea, etc.) | X-ray or Cobalt Treatment |
| Congenital Heart Lesions | Positive Blood Test for H.I.V. | Epilepsy or Seizures | Bruise Easily | Arthritis |
| Scarlet Fever | Hepatitis A (infectious) | Fainting or Dizzy Spells | Emphysema | Rheumatism |
| Artificial Heart Valve | Hepatitis B (serum) | Nervousness | Tuberculosis (TB) | Cortisone or Steroid Medicine |
| Heart Pacemaker | Hepatitis C | Psychiatric Treatment | Asthma | Artificial Joints (Hip, Knee, etc.) |

Are there any other health problems or limitations that we should be aware of? _____

Signature of Responsible Party (if patient is a Minor) _____ Date _____

I understand I am responsible for all dental services rendered and fees incurred, irregardless of assistance from my dental insurance. My payment preference is: Cash/Check Credit Card (MC, Discover, Visa or AMEX)