# PERSONAL HISTORY
# LOUIS RAFETTO, D.M.D.

*(All information will be held in strict confidence)*

Date _____ Update _____
(For Office Use Only)

## Patient Information

Patient's Name _____ Best Phone # _____ Home / Cell / Work

Alt. Phone # _____ Home / Cell / Work

Street Address _____ City _____ State _____ Zip Code _____

Patient's Social Secuirty No. _____ Date of Birth _____ Age _____

Employer_____ Occupation _____Work Phone # _____

## Guardian Information ( if patient is a minor)

Mother's Name _____ Mother's Social Security No. _____ Date of Birth _____

Employer _____ Best Phone # _____

Father's Name _____ Father's Social Security No. _____ Date of Birth _____

Employer _____ Best Phone # _____

Guardian's Address (if different than above) _____

## Insurance Information

Primary Dental Ins. Co. _____ ID# _____ Insured Name _____

Secondary Dental Ins. Co. _____ ID# _____ Insured Name _____

Primary Medical Ins. Co. _____ ID# _____ Insured Name _____

Secondary Medical Ins. Co. _____ ID# _____ Insured Name _____

**If you have listed insurance coverage above, please sign the following statement, unless you wish to pay in full at the time of service.**
**I hereby authorize payment of benefits directly to Dr. Rafetto for services performed.**

Signature of Insured _____

Who referred you to us? _____ General Dentist _____

What is your current dental problem? _____ When was your last dental visit? _____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

* YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT *

I have received a copy of this office's Notice of Privacy Practices.

_____

Signature of patient (guardian, if the patient is a minor) Date

**PLEASE COMPLETE BACK OF FORM**

## MEDICAL-DENTAL HISTORY

*(Circle one or complete the blanks)*

Height _____ Weight _____

Are you in good health? YES NO

Do you have any medical problems? YES NO

Has your health status changed in the past year? YES NO

Are you under a physician's care at this time? YES NO

For what?_____

Who is/are your physician(s)? _____

Have you ever been hospitalized? YES NO

If yes, for what_____

What operations have you had? _____

**What drugs, medicines, or other things are you allergic to?** _____

_____

**Do you have a latex allergy?** YES NO

**Do you take anticoagulants (blood thinners)?** YES NO

**Do you take an antibiotic before dental procedures?** YES NO

Do you use marijuana or other "street drugs"? YES NO

Do you smoke? YES NO

If yes, how much _____

Do you use alcohol? YES NO

If yes, how much? _____

**What drugs, medicines and supplements are you taking now?** _____

_____

_____

_____

Are you pregnant? YES NO

### Do you have or have you had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Heart Disease | YES | NO | Diabetes | YES | NO |
| Heart Murmur | YES | NO | Blood Disease | YES | NO |
| Rheumatic Fever | YES | NO | Prolonged Bleeding when Cut | YES | NO |
| Heart Pacer | YES | NO | Recent Weight Change | YES | NO |
| Blood Pressure Problem | YES | NO | Epilepsy or Seizure Disorder | YES | NO |
| Chest Pain | YES | NO | Artificial Joints | YES | NO |
| Lung Disease | YES | NO | Contact Lenses | YES | NO |
| Asthma | YES | NO | Sinus or Nasal Problems | YES | NO |
| Tuberculosis | YES | NO | TMJ/TMD Problems | YES | NO |
| Frequent Cough | YES | NO | Mental/Emotional Disorder | YES | NO |
| Shortness of Breath | YES | NO | Immune Deficient State | YES | NO |
| Liver Disease | YES | NO | Sexually Transmitted Disease | YES | NO |
| Hepatitis | YES | NO | Have you had any problems with: | | |
| Kidney Disease | YES | NO | - Local Anesthesia (Novocaine) | YES | NO |
| Fainting or Dizziness | YES | NO | - General anesthesia or sedation | YES | NO |

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? YES NO

Do you wish to talk with the doctor privately about anything? YES NO

I certify that all information on this history form is true and correct.

_____

Signature of patient (guardian, if the patient is a minor)