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 _____ Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____

Best Phone # _____ 2nd Phone # _____

Patient's Social Security No. _____ Employer _____

Occupation _____ Work Phone # _____

If Minor, Parent's Name _____ Date of Birth_____

Primary Dental Insurance Information

Insurance Company _____ SS # or ID # _____ Group _____

Subscriber's Name _____ Relationship _____ Date of Birth _____

Address (If different from patient) _____ _____ _____ _____
Street Address City State Zip Code

Do you have secondary Dental Insurance? YES or NO Secondary Dental Insurance Company _____

Primary Medical Insurance Information

Insurance Company _____ SS # or ID # _____ Group _____

Subscriber's Name _____ Relationship _____ Date of Birth _____

Address (If different from patient) _____ _____ _____ _____
Street Address City State Zip Code

Do you have secondary Medical Insurance? YES or NO Secondary Medical Insurance Company _____

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 _____

General Dentist _____ Who referred you to us? _____

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 ACKNOWLEGEMENT

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

PLEASE COMPLETE BACK OF FORM

Signature of patient or guardian _____ Date _____

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? _____

_____

Are you pregnant? YES NO

Do you have any artificial joints? YES NO

Do you take blood thinners? YES NO

Are you required to take antibiotic before dental visit? 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?

_____

_____

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

_____

Do you have latex allergy? YES NO

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

Heart Disease YES NO

Heart Murmur YES NO

Heart Pacer YES NO

Blood Pressure Problem YES NO

Chest Pain YES NO

Lung Disease YES NO

Asthma YES NO

Tuberculosis YES NO

Frequent Cough YES NO

Shortness of Breath YES NO

Liver Disease YES NO

Hepatitis YES NO

Kidney Disease YES NO

Fainting or Dizziness YES NO

Cognitive Disorder YES NO

Neurological Disorder YES NO

Diabetes YES NO

Blood Disease YES NO

Prolonged Bleeding when Cut YES NO

Recent Weight Change YES NO

Epilepsy or Seizure Disorder YES NO

Sleep Apnea YES NO

Contact Lenses YES NO

Sinus or Nasal Problems YES NO

TMJ/TMD Problems YES NO

Mental/Emotional Disorder YES NO

Immune Deficient State YES NO

Sexually Transmitted Disease YES NO

Have you had any problems with: YES NO

- Local Anesthesia (Novocaine) 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 to a 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) _____