

Robert J. Moretta, D.D.S.

Thank you for choosing our office for your dental treatment. In order that we may be more effective in meeting your needs, please complete this entire form in full.

Name	_____	Age	_____	Spouse's Name	_____
Residence Address	_____	City	_____	Zip	_____
Mailing Address	_____	City	_____	Zip	_____
Residence Phone	_____	Cell Phone	_____	E Mail	_____
Driver's License No.	_____	Social Security No.	_____	Birth Date	_____
Married	_____	Single	_____	Divorced	_____
	_____	Separated	_____	Widowed	_____
Employed by	_____	Occupation	_____		
If Self-employed, name of business	_____				
Business Address	_____	Bus. Phone	_____		
Spouse Employed by	_____	Occupation	_____		
If Self-employed, name of business	_____				
Bus. Phone	_____				
Name of nearest relative not living with you	_____			Relation	_____
Address	_____			Phone	_____
Name of Physician	_____	City	_____	Phone	_____
Former Dentist	_____	City	_____	Phone	_____
Purpose of Appointment	_____				
Is this visit for emergency dental care?	_____				
Whom may we thank for referring you?	_____				

Person responsible for this account	_____	Relation	_____		
Address	_____			Phone	_____
Insurance Company Name	_____	Group No.	_____		
Social Security Number of Insured	_____	Insured Birth Date	_____		
Secondary Insurance Company Name	_____	Group No.	_____		
Social Security Number of Insured	_____	Insured Birth Date	_____		

Comments	_____				

Please complete other side

Medical History

1. Are you under medical treatment now?.....yes no
Explain _____
2. Have you had a joint or heart valve replaced?...yes no
3. Are you allergic to any of the following?
Local anesthetics (e.g. Novocaine, etc).....yes no
Aspirin.....yes no
Codeine.....yes no
Penicillin.....yes no
Erythromycin.....yes no
Tetracycline or other antibiotics.....yes no
Other _____
4. Do you use tobacco?.....yes no
5. Do you use recreational drugs (ie. cocaine)?....yes no

6. Are you taking any medications including non-prescription medicine?.....yes no
If yes, what medication(s) are you taking _____

7. Women only:
a) Are you pregnant or think you may be?.....yes no
b) Are you taking birth control pills?.....yes no

8. Do you have or have you had any of the following? (Please check known conditions)

- | | | |
|-----------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> AIDS or HIV infection | <input type="checkbox"/> Difficulty with Swallowing |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Mitro Valve Prolapse (MVP) | <input type="checkbox"/> Sexual Transmitted Disease | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Herpes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies/Hay Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | _____ |
| <input type="checkbox"/> Heart Murmur | | |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Arthritis | |
| | <input type="checkbox"/> Sinus Trouble | |

Dental History

1. How long has it been since your last complete series of oral X-rays(not check up X-rays)? _____
2. How long since your last dental treatment? _____
3. Have you ever had local anesthetic (novocaine).....yes no
4. Have you ever had any serious trouble with any previous dental treatment?.....yes no
5. Have you ever been told that you have gum disease (pyorrhea)?.....yes no
6. Do you clinch or grind your teeth?.....yes no
7. Do you snore?.....yes no
8. Does dental treatment make you nervous.....yes no If yes, ___slightly___ moderate ___extremely
9. Would you desire to be pre-sedated or use Nitrous oxide?.....yes no
10. Is it important to you to keep your natural teeth?.....yes no
11. If you could wave a magic wand and change anything about your smile, what would it be? _____

12. If there was a simple, inexpensive way to whiten your teeth, would you be interested? _____
13. Why did you leave your last dentist? _____
14. What did you like most about any dentist you've ever seen? _____
15. What did you like least about any dentist you've ever seen? _____

Consent

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have changes in my health, or if my medicines change, I will inform the doctor. I authorize the doctor to take radiographs, study models or any other diagnostics aids deemed appropriate in order to make a thorough diagnosis. I also authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated after proper explanation, alternatives and consequences have been given to me.

Signature _____ Date _____