



William Fitzgerald DDS

Family & Cosmetic Dentistry

Welcome

to the office of Dr. William Fitzgerald

We are pleased that you have selected us to provide dental care for you.
So that we may serve you better, please complete both sides of the patient information form.

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____

City, State _____ Zip _____

Home Phone _____ Cell Phone _____

Birth date _____ Sex M ___ F ___ Social Security Number _____

Married _____ Single _____ Spouse's Name _____

Employer _____ Employer Phone # _____ Ext. _____

Student: Yes ___ No ___ Name of School _____

Name of Emergency Contact _____ Relationship to Patient _____

Emergency Contact Phone Number _____

Whom may we thank for referring you to our office _____

DENTAL INSURANCE INFORMATION

Last Name of Subscriber _____ First Name _____ Middle Initial _____

Relationship to Patient; Self ___ Spouse ___ Dependent ___

Address _____

City, State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Employer Phone # _____ Ext. _____

Birth date _____ Sex: M ___ F ___ Social Security Number _____

Name of Insurance Co. _____ Phone Number _____

I.D. Number _____ Group Number _____

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SECONDARY INSURANCE INFORMATION

Last Name of Subscriber _____ First Name _____ Middle Initial _____

Relationship to Patient; Self ___ Spouse ___ Dependent ___

Address _____

City, State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Employer Phone # _____ Ext. _____

Birth date _____ Sex: M ___ F ___ Social Security Number _____

Name of Insurance Co. _____ Phone Number _____

I.D. Number _____ Group Number _____

AUTHORIZATION

I Certify that I have read the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for my payment in full no later than 30 days after all services rendered on my behalf or my dependents. If I do not pay, I agree to pay all court cost/collection fees that may occur because of non-payment on my account. All crowns, partials, veneers, dentures, and onlays/inlays must be seated no later than 30 days of preparation date to guarantee to fit properly. Patient is responsible for all costs of remake if not seated within 30 days.

SIGNATURE OF PATIENT (or parent if minor): _____

Date: _____

DENTAL HISTORY

So that we may provide you with the best possible care please complete both sides of this dental/medical history form. All information is completely confidential.

Reason for today's visit _____

Date of last dental visit _____ Date of last cleaning _____

Former dentist _____ City, State _____

How often do you brush your teeth? _____ Floss? _____

Are any of your teeth sensitive to:

Hot or cold	Yes	No
Sweets	Yes	No
Biting or chewing	Yes	No
Do your gums bleed or hurt	Yes	No

Have you noticed any loose teeth or change in your bite	Yes	No
Does food tend to become caught between your teeth	Yes	No

Do you:

Clench or grind your teeth	Yes	No
Bite your lips or cheeks	Yes	No
Mouth breathe while awake or asleep	Yes	No
Have tired jaws or jaw pain	Yes	No
Smoke or chew tobacco	Yes	No
Have tooth pain	Yes	No

Have you ever had:

Orthodontic Treatment	Yes	No
Oral surgery	Yes	No
Periodontal treatment	Yes	No

Have you experienced:

Clicking or popping of jaw	Yes	No
Difficulty opening or closing your mouth	Yes	No
Bad breath	Yes	No
Blisters on mouth or lips	Yes	No
dry mouth	Yes	No
Sores/growths in mouth	Yes	No
Mouth pain when brushing	Yes	No
Swollen or tender gums	Yes	No

Are you satisfied with your teeth's appearance? Yes No

Do you feel nervous about having dental treatment? Yes No

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe: _____

HEALTH HISTORY

Physician's Name _____ Date of last visit: _____

Please indicate if you have now or have had in the past:

AIDS	Yes	No	Epilepsy	Yes	No
Anemia	Yes	No	Fainting or dizziness	Yes	No
Arthritis, rheumatism	Yes	No	Glaucoma	Yes	No
Artificial heart valves	Yes	No	Headaches	Yes	No
Artificial joints	Yes	No	Heart murmur	Yes	No
Asthma	Yes	No	Heart problems	Yes	No
Hepatitis Type _____	Yes	No	Tonsillitis	Yes	No
Bypass surgery	Yes	No	Herpes	Yes	No
Abnormal bleeding w/extractions, surgery	Yes	No	High blood pressure	Yes	No
Blood disease	Yes	No	HIV positive	Yes	No
Cancer	Yes	No	Kidney disease	Yes	No
Liver disease	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Thyroid problems	Yes	No
Circulatory problems	Yes	No	Low blood pressure	Yes	No
Congenital heart Lesions	Yes	No	Mitral valve prolapse	Yes	No
Venereal disease	Yes	No	Nervous problems	Yes	No
Cough, persistent or bloody	Yes	No	Pacemaker	Yes	No
Diabetes	Yes	No	Are you pregnant	Yes	No
Emphysema	Yes	No	Are you nursing	Yes	No
Wear contact lenses	Yes	No	Psychiatric care	Yes	No
Scarlet fever	Yes	No	Radiation Treatment	Yes	No
Sinus trouble	Yes	No	Respiratory disease	Yes	No
Special diet	Yes	No	Rheumatic fever	Yes	No
Stroke	Yes	No	Shortness of breath	Yes	No
Swollen neck glands	Yes	No	Ulcer	Yes	No
Unexplained weight loss	Yes	No	Stints/shunts	Yes	No
			Swelling feet/ankles	Yes	No
			Tumor growth on head or neck	Yes	No

Please list all medications you are currently taking: _____

Are you allergic to any of the following:

____ Aspirin	____ Latex	Other allergies: _____
____ Barbituates (sleeping pills)	____ Local anesthetics	_____
____ Codeine	____ Penicillin	_____
____ Iodine	____ Sulfa	_____