

PECCOLE FAMILY DENTAL

9580 W. Sahara Ave., Suite 190 • Las Vegas, Nevada 89117
702.242.4680

Date / /
MO. DAY YR.

INFORMATION REQUIRED FOR PATIENT'S CASE HISTORY FILE

-- Please Print and Fill in Completely --

1 <input type="checkbox"/> ADULT <input type="checkbox"/> CHILD PATIENT	NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE NO. _____ HOME _____ WORK _____	SEX <u> </u> / <u> </u> / <u> </u> M F BIRTHDATE <u> </u> / <u> </u> / <u> </u> MO. DAY YR. AGE SOCIAL SECURITY NUMBER _____ MARITAL STATUS _____ MARRIED _____ SINGLE _____ DIV/SEP _____ W																		
2	REFERRER BY _____																			
3 PARTY RESPONSIBLE FOR PAYMENT	If adult patient, enter "self" as responsible party and complete next selections. If minor child, enter responsible parent and complete next sections. NAME _____ SEX <u> </u> / <u> </u> / <u> </u> M F BIRTHDATE <u> </u> / <u> </u> / <u> </u> MO. DAY YR. AGE SOCIAL SECURITY NUMBER _____ MARITAL STATUS _____ MARRIED _____ SINGLE _____ DIV/SEP _____ W ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE NO. _____ HOME _____ WORK _____																			
4 EMPLOYER OF RESPONSIBLE PARTY	NAME _____ OCCUPATION _____ ADDRESS _____ NO. _____ STREET _____ CITY _____ STATE _____ ZIP _____ PHONE _____																			
5 SPOUSE (husband or wife)	NAME _____ FIRST _____ MID. INITIAL _____ LAST _____ SEX <u> </u> / <u> </u> / <u> </u> M F BIRTHDATE <u> </u> / <u> </u> / <u> </u> MO. DAY YR. DRIVER'S LICENSE _____ EMPLOYER _____ ADDRESS _____ NO. _____ STREET _____ CITY _____ STATE _____ ZIP _____ PHONE _____																			
6 NEAREST RELATIVE OR FRIEND	NAME _____ FIRST _____ MID. INITIAL _____ LAST _____ RELATIONSHIP TO YOU _____ ADDRESS _____ NO. _____ STREET _____ CITY _____ STATE _____ ZIP _____ PHONE _____																			
7 GROUP OR PRIVATE INSURANCE	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: middle;">P R I M A R Y</td> <td style="width: 50%;">GROUP NO. (If applicable) _____</td> <td style="width: 45%;">INSURANCE CO. _____</td> </tr> <tr> <td></td> <td>SUBSCRIBER NO. _____</td> <td>MAILING ADDRESS _____</td> </tr> <tr> <td></td> <td>SUBSCRIBER'S NAME _____</td> <td></td> </tr> <tr> <td style="text-align: center; vertical-align: middle;">S E C O N D A R Y</td> <td>GROUP NO. (If applicable) _____</td> <td>INSURANCE CO. _____</td> </tr> <tr> <td></td> <td>SUBSCRIBER NO. _____</td> <td>MAILING ADDRESS _____</td> </tr> <tr> <td></td> <td>SUBSCRIBER'S NAME _____</td> <td></td> </tr> </table>		P R I M A R Y	GROUP NO. (If applicable) _____	INSURANCE CO. _____		SUBSCRIBER NO. _____	MAILING ADDRESS _____		SUBSCRIBER'S NAME _____		S E C O N D A R Y	GROUP NO. (If applicable) _____	INSURANCE CO. _____		SUBSCRIBER NO. _____	MAILING ADDRESS _____		SUBSCRIBER'S NAME _____	
P R I M A R Y	GROUP NO. (If applicable) _____	INSURANCE CO. _____																		
	SUBSCRIBER NO. _____	MAILING ADDRESS _____																		
	SUBSCRIBER'S NAME _____																			
S E C O N D A R Y	GROUP NO. (If applicable) _____	INSURANCE CO. _____																		
	SUBSCRIBER NO. _____	MAILING ADDRESS _____																		
	SUBSCRIBER'S NAME _____																			
8	SIGNATURE HERE I hereby authorize payment of Dental Benefits to the doctor _____ <div style="text-align: right;">Signature</div>																			

PECCOLE FAMILY DENTAL

MEDICAL HISTORY

9580 W. Sahara Ave., Suite 190 • Las Vegas, Nevada 89117
702.242.4680

Patient Name _____

5. Are you aware of having an allergic (or adverse) reaction to any medication or substance.....Yes No
If yes, please list _____
6. Have you been a patient in the hospital during the past five years.....Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.
- | | | |
|---|--|---|
| Heart (Surgery, Disease, Attack) Yes No | Diabetes.....Yes No | A.I.D.S..... Yes No |
| Chest Pain.....Yes No | Thyroid Problems..... Yes No | H.I.V. Positive.....Yes No |
| Congenital Heart Disease..... Yes No | Glaucoma..... Yes No | Blood Transfusion..... Yes No |
| Heart Murmur..... Yes No | Emphysema..... Yes No | Hemophilia..... Yes No |
| High Blood Pressure..... Yes No | Chronic Cough..... Yes No | Sickle Cell Disease..... Yes No |
| Mitral Valve Prolapse..... Yes No | Tuberculosis..... Yes No | Bruise Easily..... Yes No |
| Artificial Heart Valve..... Yes No | Asthma..... Yes No | Liver Disease..... Yes No |
| Heart Pacemaker..... Yes No | Latex Sensitivity.....Yes No | Neurological Disorders..... Yes No |
| Rheumatic Fever..... Yes No | Allergies or Hives..... Yes No | Epilepsy or Seizures..... Yes No |
| Arthritis/Rheumatism..... Yes No | Sinus Trouble..... Yes No | Fainting or Dizzy Spells..... Yes No |
| Swollen Ankles..... Yes No | Radiation Therapy..... Yes No | Psychiatric/Psychological Care.. Yes No |
| Stroke..... Yes No | Chemotherapy..... Yes No | |
| Artificial Joints (hip, knee, etc.)... Yes No | Tumors..... Yes No | |
| Other Prosthesis or Implants..... Yes No | Hepatitis A (infectious) B (serum)Yes No | |
| Kidney Trouble..... Yes No | Venereal Disease..... Yes No | |
| Ulcers..... Yes No | | |
8. Do you use more than two pillows to sleep..... Yes No
9. Have you lost or gained more than 10 pounds in the past year.....Yes No
10. Do you have or have had any disease, condition, or problem not listed.....Yes No
If yes, please list _____
11. **Women:** Are you: **Pregnant?** Yes, ____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

CONSENT OF TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to preform all recommended treatment mutually agreed upon by me and to emply such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for the complete recital of any possible complications.
4. I agree that I will give 48 hours notice, in the event that I find it necessary to cancel an appointment. If 48 hours notice is not given I understand that a cancellation fee of \$100.00 will be applied to my account.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____

Parent/ Responsible Party's Signature _____ Relationship to Patient _____

**PECCOLE
FAMILY DENTAL**

DENTAL HISTORY

9580 W. Sahara Ave., Suite 190 • Las Vegas, Nevada 89117
702.242.4680

Date: _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____

What was done at your last dental visit? _____

How often do you have dental examinations? _____

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

What other dental aids do you use? (automatic tooth brush, toothpick, water pik, etc) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If yes, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches, or shoulder aches? Yes No

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

Would you like to keep all of your teeth all of your life? Yes No

Would you like your teeth whiter? 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 _____

1. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? Yes No

3. Are you taking medication, drugs, or pills now? Yes No

If yes, please list name and dosage _____

4. Have you ever taken prescription medications for weight loss (diet pills) Yes No

If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phenpermine)

Yes No Pondimen (Fenfluramine)

Yes No Redux (Dexfenfluramine)

If yes to any of the above, did you have a medical exam for heart issues? Yes No