Welcome to
Raffaella Armstrong D.M.D.

Patient Information

Today's Date: _____

Name: _____Birth date: _____

Age ____SS#_____ Birthplace_____

Address: _____City: _____ State ____Zip_____

Cell Phone: _____ Home Phone: _____

Work address_____

City: _____State _____Zip_____ phone # _____

E-mail: _____Occupation_____

The best way to reach you is by ☐ Phone ☐ E-mail ☐ Text

How did you hear about us? _____

Person to contact in case of emergency _____Phone: _____

Reason for today visit? _____

Patient Medical History

Are you allergic to or had any reaction to the following?

Local Anesthetics (e.g. Novocain) Yes [ ] No[ ]
Penicillin or any other Antibiotic Yes [ ] No[ ]
Sulfa Drugs Yes [ ] No[ ]
Barbiturates Yes [ ] No[ ]
Sedatives Yes [ ] No[ ]
Iodine Yes [ ] No[ ]
Aspirin Yes [ ] No[ ]
Any Metals (nickel, metal, etc.) Yes [ ] No[ ]
Latex Rubber Yes [ ] No[ ]
Other Yes [ ] No [ ]

Are you under medical treatment? Yes [ ] No [ ]
Have you ever been hospitalized Yes [ ] No [ ]
For any operation or serious illness?
If yes, explain _____
_____

Are you taking any medication? Yes [ ] No [ ]
If yes what medications _____
_____

Do you use tobacco? Yes [ ] No [ ]
Have you taken Fen- Phen/Redux? Yes [ ] No [ ]
Do you use controlled substances? Yes [ ] No [ ]

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

- High Blood Pressure	Yes [ ] No [ ]	- Heart Disease	Yes [ ] No [ ]	Stroke	Yes [ ] No [ ]
- Heart Attack	Yes [ ] No [ ]	-Cardiac Pacemaker	Yes [ ] No [ ]	Hay Fever	Yes [ ] No [ ]
- Rheumatic Fever	Yes [ ] No [ ]	- Heart Murmur	Yes [ ] No [ ]	Tuberculosis	Yes [ ] No [ ]
- Seizures	Yes [ ] No [ ]	-Angina	Yes [ ] No [ ]	Radiation	Yes [ ] No [ ]
- Asthma	Yes [ ] No [ ]	-Anemia	Yes [ ] No [ ]	Glaucoma	Yes [ ] No [ ]
- Low Blood Pressure	Yes [ ] No [ ]	- Emphysema	Yes [ ] No [ ]	Recent Weight Loss	Yes [ ] No [ ]
-Cancer	Yes [ ] No [ ]	Liver Disease			
- Leukemia	Yes [ ] No [ ]	-Arthritis	Yes [ ] No [ ]	Heart Trouble	Yes [ ] No [ ]
- Diabetes	Yes [ ] No [ ]	-Joint Replacement	Yes [ ] No [ ]	Respiratory Problem	Yes [ ] No [ ]
- Kidney Disease	Yes [ ] No [ ]	-Jaundice/ Hepatitis	Yes [ ] No [ ]	Mitral Valve Prolapse	Yes [ ] No [ ]
- Aids or HIV	Yes [ ] No [ ]	- Sexual disease	Yes [ ] No [ ]	Other	Yes [ ] No [ ]
- Thyroid Problem	Yes [ ] No [ ]	- Chest Pain	Yes [ ] No [ ]		

For females only: Are you pregnant? Yes [ ] No [ ] Due date _____ Are you nursing? Yes [ ] No [ ]
Are you taking birth control pills? Yes [ ] No [ ]
Are you taking any bisphosphonate medication (i.e. Zometa, Aredia) Yes [ ] No [ ]

Patient Dental History

Former Dentist _____Date of last exam _____Date of last dental x-rays_____

1. Do your gums bleed while brushing or flossing? Yes [ ] No[ ]	6. Do you have frequent headaches? Yes [ ] No[ ]
2. Are your teeth sensitive to hot or cold liquids? Yes [ ] No[ ]	7. Do you grind your teeth? Yes [ ] No[ ]
3. Do you feel any pain in your mouth? Yes [ ] No[ ]	8. Do you bite your lips or cheeks? Yes [ ] No[ ]
4. Do you have any sores or lumps in mouth? Yes [ ] No[ ]	9. Have you had difficult extractions? Yes[ ] No[ ]
5. Have you experienced any of the following problems in your jaw?	10. Have you had prolonged bleeding? Yes[ ] No[ ]
Clicking Yes [ ] No[ ]	11. Have you had ortho.treatment? Yes[ ] No[ ]
Pain Yes [ ] No[ ]	12. Do you wear dentures or partials? Yes[ ] No[ ]
Difficulty opening or closing Yes [ ] No[ ]	13. Do you like your smile? Yes[ ]No[ ]
Difficulty in chewing Yes [ ] No[ ]	14. Have you had head, neck or jaw injuries? Yes [ ] No[ ]
	15. Do you Snore? Yes [ ] No [ ]

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

*X*_____ *Date*_____ *X*_____ *Date*_____

Signature of patient *Doctor's Signature*

AKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgment **

I, _____, have received a copy of this Office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement

○ Other (Please Specify) Please use this space below to whom you would like us to release information to. Also Specify If you do not wants us to release any information.

_____

_____

_____

_____

_____

_____