Cosmetic & Family Dentistry  **Steven J. Rinaldi D.M.D.**

Patient Information

Patient Name: _____Date:_____
Last First MI
Male__ Female__ Married__ Single__ Child__ Other _____ Birth Date:_____
Social Security #: _____
Phone (Home): _____ (Work): _____ Ext:_____
Mobile/Cell _____ Best time to call:_____
E-Mail:_____ Fax: _____
Address:_____
_____
City State Zip Code

Health Information

Previous Dentist: _____Date of Last Dental Visit: _____
Reason for this visit:_____

Have you ever had any of the following? Please circle those that apply:

AIDS	Fainting	Pacemaker
Allergies_____	Glaucoma	Penicillin Allergy
Arthritis	Growths	Pregnancy Due Date_____
Artificial Joints	Hay Fever	Psychiatric/Psychological Care
Artificial Heart Valve	Head Injuries	Radiation Treatment
Asthma	Heart (Attack, Disease, Surgery)	Respiratory Problems
Blood Disease	Heart Murmur	Rheumatic Fever
Bruise Easily	Hemophilia	Rheumatism
Cancer	Hepatitis	Sinus Problems
Cold Sores/Fever Blisters	High Blood Pressure	Smoke/Chew Tobacco
Contact Lenses	H.I.V. Positive	Stomach Problems
Cortisone Medication	Jaundice	Stroke
Diabetes	Kidney Disease	Tuberculosis
Diet (Special/Restricted)	Latex Sensitivity	Tumors
Dizziness	Liver Disease	Thyroid Problems
Emphysema	Mental Disorders	Ulcers
Epilepsy	Mitral Valve Prolapse	Venereal Disease
Excessive Bleeding	Nervous Disorders	

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Allergic/Adverse Reaction To Medication or Any Substance, Please specify:_____

_____

Other:_____

Have you ever had any complications following dental treatment? Yes No

If yes, please explain_____

Have you been admitted to a hospital or needed emergency care during the past two years?
Yes No

If yes, please explain:_____

Are you now under the care of a physician? Yes No
If yes, please explain:_____

Name of Physician:_____Phone #_____

Do you have any health problems that need further clarification? Yes No
If yes, please explain:_____

Are you taking any medications? Yes No
Purpose?_____
Please list_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____Date:_____
Signature of patient, parent or guardian

_____Date: _____
Signature of Doctor

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Responsible Party Information

The following is the person responsible for payment

Name:_____

Married___ Single___Other ___

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell):_____

Address_____

City_____State_____ Zip Code_____

Employment Information

The following is for the person responsible for payment

Employer Name_____Occupation_____

Address_____
City_____State_____ Zip Code_____

Insurance Information

Name of Insured: _____
Is insured a patient? Yes No

Last_____First_____MI_____
Insured's Birth Date: _____ ID #: _____Group #_____

Insured's Address_____
City_____State_____ Zip Code_____

Insured's Employer Name_____

Address_____
City_____State_____Zip Code_____

Patient's relationship to insured: Self_____ Spouse _____ Child_____ Other_____

Insurance Plan Name and Telephone_____
_____

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Consent for Services

I hereby authorize Dr. Rinaldi and/or staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Rinaldi to make a thorough diagnosis of my/my child's dental needs. Upon such diagnosis, I authorize Dr. Rinaldi to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of ninety (90) days from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient:_____
Signature of guarantor of payment/responsible party

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Patient Dental History

Name of previous dentist and location? _____
Date of last exam_____

Do your gums bleed while brushing or flossing? Yes No

Are your teeth sensitive to hot or cold? Yes No

Do you feel pain in any of your teeth? Yes No
Which one(s)?_____

Do you experience any discomfort in your teeth while chewing? Yes No
Which one(s)?_____

Are you experiencing anything else with your teeth you would like to mention?_____
_____

Referral Information

Whom may we thank for referring you to our practice?

Another patient___ Friend____ Physician____ Another Dental Office____ Newspaper Ad____
Other_____

Name of person or office referring you to our practice:
_____

Smile Evaluation Information

Do you like the appearance of your teeth; smile? Yes No
If not, explain_____
_____

Do you have spaces you don't like? Yes No
If yes, explain_____
_____

Do you like the color of your teeth? Yes No
If not, explain_____
_____

Do you like the shape of your teeth? Yes No
If not, explain_____
_____

Are there old fillings or dental work you don't like looking at? Yes No
If yes, explain_____
_____

What would you like to change the most in the appearance of your teeth?_____
_____