COTTONWOOD DENTAL

DAVID GIAQUINTO, DDS

Welcome to Our Office

IN ORDER TO PROVIDE A THOROUGH EXAM PLEASE FILL IN THE FOLLOWING INFORMATION:

Your Full Name: Mr Mrs Ms Miss Dr _____ Age_____ Birthdate_____

Name of Spouse_____ e-mail address_____ **Referred By**_____

Residence Address _____ City _____ State_____ Zip_____ Home Ph.#_____

Employed By_____ Business Ph.# _____ Cell Ph.#_____

Present Position_____ Soc. Sec.#_____ Spouse's SS#_____

Spouse Employed By _____ Method of Payment: Check ☐ Cash ☐ Credit Card ☐

Who is Responsible for Payment?_____ Dental Ins. Co._____

Policy Holders Name_____ Birthdate of Policy Holder_____

In Case of Emergency: Nearest Friend or Relative Not Living With You_____ Phone #_____

HAVE YOU EVER HAD	YES		YES		YES
Heart Disease/Heart Surgery	☐	Diabetes/Hypoglycemia	☐	Arthritis	☐
Rhuematic Fever/Heart Murmur	☐	Epilepsy/Seisures/Fainting Spells	☐	Anemia/Leukemia/Prolonged Bleeding	☐
Congenial Heart Lesions	☐	Cancer or Tumors	☐	VD (Syphilis, Gonorrhea)	☐
Heart Attack/Artereosclerosis	☐	Tuberculosis	☐	HIV (Aids) Pos. or Exp.	☐
Pacemaker	☐	Liver Disease/Jaundice/Hepatitis	☐	Prosthetic Devices (Knee, Hip, Etc.)	☐
Prosthetic Heart Valves	☐	Kidney/Bladder Trouble	☐	Do You Use Tobacco?	☐
Abnormal Blood Pressure	☐	Sinus Trouble/Hayfever	☐	IV Drug Use	☐
Lung Disease/Emphesema/Asthma	☐	Stroke/Glaucoma	☐	Gum Surgery or Treatment	☐

HAVE YOU EVER EXPERIENCED AN UNUSUAL REACTION OR ALLERGY TO ANY OF THE FOLLOWING?

	YES		YES		YES
Penicillin	☐	Codeine/Demerol	☐	Nitros Oxide	☐
Erythromycin	☐	Sedatives, Sleeping Pills	☐	Other Medications_____	☐
Aspirin	☐	Dental Anesthetics (Lidocaine)	☐	_____	

Please List Any Medications You Are Currently Taking _____

Are You Under The Active Care of a Physician At This Time? Yes ☐ No ☐ Why?_____

Date of Last Physical Exam _____ Have You Been Hospitalized In The Last Two Years? ☐ Why?_____

Are Your Teeth Sensitive To HOT ☐ COLD ☐ SWEET ☐ BITING ☐ Are You Pregnant ☐ Lactating ☐

Purpose of This Dental Visit_____

Are You Having Any Dental Concerns At This Time? Explain _____

Do You Have Any Fears Concerning Dentistry? Explain _____

Would You Like Information on Professional Whitening ☐ Ultrasonic Tooth Brush ☐ Fluoride ☐ Breath Prescription Kits ☐

QUESTIONS:	YES		YES
Would you like a WHITER, BRIGHTER SMILE?	☐	Would you prefer SHOT-LESS DENTISTRY?	☐
Would you like to discover MICRO DENTISTRY?	☐	Are you concerned about BAD BREATH?	☐
Are you concerned about MERCURY FILLINGS in your mouth?	☐	Do you have frequent HEADACHES?	☐
Do Your GUMS BLEED, HURT or SWELL?	☐	Do you CLENCH/GRIND your teeth?	☐
SWELLING or lumps on neck or inside mouth?	☐	Do you have PAIN in your HEAD or NECK?	☐
Have you NEGLECTED your teeth?	☐	Have you had a recent ACCIDENT? (Auto)	☐
Were your past dental treatment investments SUCCESSFUL?	☐	Do you want to use (Nitrous) RELAXING GAS?	☐
Were you dissatisfied with your LAST DENTIST?	☐	Do you desire to KEEP YOUR Natural TEETH?	☐
Why?_____		Would you change the APPEARANCE OF YOUR SMILE?	☐

CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5 % finance charge (18% annually) will be added to any balance over 60 days. I understand, where appropriate, credit bureau reports may be obtained. I direct insurance benefits payable to the attending dentist.

Patient_____ Date_____