JOHN JOSEPH BACINO D.D.S

560 Brockton Street
Fletcher Hills, CA 92020

NAME: _____DATE:_____
I prefer to be called:_____**male:_____female:_____**
Birthdate:_____Age:_____SS#:_____
Driver's license #:_____
Home address:_____
City:_____ Zip code:_____
Home #:_____Work #_____
Cell #:_____E-mail address:_____
Employer:_____
Employer address:_____
Whom may we thank for referring you:_____
Other family members seen by us:_____
Name of spouse:_____
Person responsible for account:_____
(patients with insurance assigning benefits: I understand if my insurance carrier does not reimburse John Joseph Bacino D.D.S. for services rendered I am responsible for any and all unpaid balances on my account).

Previous/present dentist:_____
Last dental visit was:_____
Main dental concern:_____

Whom may we contact in event of emergency:
Name:_____Relation:_____
Home #:_____Work #_____
DENTAL INSURANCE INFORMATION:
Primary
Insurance company:_____
Insurance address:_____
Insurance phone #:_____
Group/plan #;_____
Subscriber's name (if different from patient):_____
Subscriber's ssn/id#:_____subscriberDob:_____
Subscriber's employer:_____
Secondary
Insurance company:_____
Insurance address:_____
Insurance phone #:_____
Group/plan #:_____
Subscriber's name (if different from patient):_____
Subscriber's ssn/id#:_____subscriberDob:_____
Subscriber's employer:_____

I have reviewed the following plan and authorize the release of any information relating to the claim. I hereby authorize the dental benefits otherwise payable to me to be paid directly to the dentist (John Joseph Bacino D.D.S).
SIGNATURE:_____

MEDICAL HISTORY

Your current physical health is: Good_____Fair_____Poor_____
Are you currently under care of a physician? Yes_____ No_____
Are you taking prescription medications: Yes_____ No_____
Please list: _____ _____ _____
_____ _____ _____
_____ _____ _____
Are you taking any Herbs, phen-phen, weight-loss drugs? Yes____No____
Please list: _____
(*for women***) Are you taking birth control? Yes_____ No_____**
Are you pregnant? Yes_____ No_____
Are you nursing? Yes_____ No_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Anemia---------- Yes_____ No_____
Radiation/chemotherapy----------Yes_____ No_____
Artificial bones/joints---------- Yes_____ No_____
Artificial valves---------- Yes_____ No_____
Asthma---------- Yes_____ No_____
Arthritis----------Yes_____ No_____
Blood transfusion---------- Yes_____ No_____
Cancer---------- Yes_____ No_____
Congenital heart defect ---------- Yes_____ No_____
Diabetes----------Yes_____ No_____
Difficulty breathing---------- Yes_____ No_____
Drug/alcohol abuse----------Yes_____ No_____
Emphysema---------- Yes_____ No_____
Epilepsy/seizures/fainting spells---------- Yes_____ No_____
Glaucoma---------- Yes_____ No_____
Heart murmur---------- Yes_____ No_____
Heart surgery---------- Yes_____ No_____
Hemophilia/abnormal bleeding---------- Yes_____ No_____
Hepatitis---------- Yes_____ No_____
High/low blood pressure ---------- Yes_____ No_____
HIV/Aids---------- Yes_____ No_____
Hospitalized for any reason:---------- Yes_____ No_____
Kidney problems---------- Yes_____ No_____
Mitral-valve prolapse---------- Yes_____ No_____
Heart conditions---------- Yes_____ No_____
Psychiatric problems----------Yes_____ No_____
Severe/frequent headaches----------Yes_____ No_____
Rheumatic/scarlet fever ---------- Yes_____ No_____
Shingles----------Yes_____ No_____
Sinus problems---------- Yes_____ No_____
Ulcers---------- Yes_____ No_____
Venereal disease ---------- Yes_____ No_____
Tuberculosis (TB)---------- Yes_____ No_____
Herpes virus---------- Yes_____ No_____
Cold sores---------- Yes_____ No_____
Alzheimer's----------Yes_____ No_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Aspirin---------- **Yes_____** **No_____**
Codeine---------- Yes_____ No_____
Erythromycin---------- **Yes_____** **No_____**
Dental Anesthetics---------- Yes_____ No_____
Latex ---------- **Yes_____** **No_____**
Penicillin---------- Yes_____ No_____
Tetracycline---------- **Yes_____** **No_____**
List any other drugs you may be allergic to: _____
_____
Are you currently in pain?---------- **Yes_____** **No_____**
Have you ever had a serious/difficult problem associated with any previous dental work? ---------- Yes_____ No_____
_____
Do you have discomfort in your jaw? ---------- **Yes_____** **No_____**
Do you like your smile?---------- Yes_____ No_____
How many times a day do you brush?_____
How many times a day do you floss? _____
How is your current dental health?---------- **Good___Fair___Poor___**

I have read and understand that the information I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will help enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

WELCOME TO OUR DENTAL FAMILY!

SIGNATURE:_____DATE:_____

UPDATE
Sign_____No change__See change above__Date_____

Sign_____No change__See change above__Date_____

Sign_____No change__See change above__Date_____