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: ____
How long there: __________________ Occupation: _______________________
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 ssc #: ______________________ subscriber Dob: ____________
Subscriber's employer: ____
Secondary
Insurance company: ____
Insurance address: ____
Insurance phone #: ____
Group/plan #: ____
Subscriber's name (if different from patient): _______________________
Subscriber's ssc #: ______________________ subscriber Dob: ____________
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: ____

I acknowledge I have received a copy of this office's Notice of Privacy Practices.

____
(patient signature) (date)

I acknowledge that I have received a copy of the Dental Materials Fact Sheet version issued in 2004.

____
(patient signature) (date)

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______