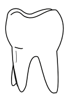

Upstate Prosthodontics, L.L.C.
With Dr. James Pizzo and Dr. Don Ridgell

Date ________________

Name ______________________ Date of Birth ______________________
Name wish to be called ______________________ Marital Status ______________________
Address ______________________ Home Phone ______________________
City ______________________ State __________ Zip Code ______________________
Social Security # ______________________ E-Mail Address ______________________
Student __________ School ______________________
Employer ______________________ Address ______________________
Occupation ______________________ Work Phone __________ Cell ______________________
Name of Spouse ______________________ Employer ______________________
Person Responsible for Payment ______________________
Address ______________________
Family Physician ______________________ Date of Last Medical Exam ______________________
Previous Dentist ______________________ Date of Last Dental Exam ______________________
Who Referred You to This Office ______________________
What dental problem caused you to seek treatment at this office? Explain ______________________

____

Preferred Day of Appointments ______________________ Time ______________________ AM/PM ______________________

------------------------------ CONFIDENTIAL MEDICAL HISTORY ------------------------------

Are you now or have you recently been under a physician's care? Reason ______________________

____

Have you ever been a patient in a hospital or had any serious illness? Explain ______________________

____

Circle any of the following which you have had or suspected:

Cancer or Tumors	Tuberculosis	Prolonged Bleeding	Rheumatic Fever	Severe Infections
Diabetes	High/Low Cholesterol	Heart Trouble	Frequent Thirst	Severe Headaches
Heart Murmur	Kidney/Bladder Trouble	Epilepsy	High/Low Blood Pressure	Anemia
Thyroid Disease	Chest Pain	Lung Disease	Glaucoma	Venereal Disease
Stroke	Pneumonia	Radiation Treatment	Shortness of Breath	Fainting Tendency
Asthma or Hay Fever	Blood Diseases	Tonsils Removed	Sinus Trouble	Liver Disease
Mental Disorders	Hepatitis or Jaundice	Slow Healing	AIDS/HIV Positive	Other

Are you taking any medications? (list) ______________________
Medication: Dosage (mg and # per day): ______________________ Action: ______________________

______________________ ______________________

Are you allergic to or suffer ill effects from: (circle)
Penicillin Codeine Nitrous Oxide Aspirin Sedatives Other

Women Only: Are you pregnant? Yes/No How many months?

Please turn over and complete the back of this form.

Are you breast feeding your child? Yes/No

Do you have any problems associated with your menstrual period? Yes/No

Are you presently taking any medicine of any kind routinely? (Hormones, Birth Control pills, etc.) Yes/No

If yes, what ______________________________

Signature of Patient or Guardian ______________________________ Date ______________

Signature of Witness ______________________________ Date ______________

Please Indicate Below How You Prefer to Pay for Your Dental Treatment

Cash ____________ Personal Check ______________ MasterCard/Visa ______________

Do you have dental insurance? Y/N - If yes complete form below.

Insured Name ______________________ Insured Date of Birth ______________

Insured Social Security # ______________________ Subscriber ID# ______________

Employer Providing Insurance ______________________________

Insurance Company Name ______________________________

Other Insurance? ______________________________

If yes, Insured Name ______________________ Insured Birth Date ______________

Insured Social Security # ______________________ Employer Providing Insurance ______________

Insurance Company Name ______________________________