



# Upstate Prosthodontics, L.L.C.

With Dr. James Pizzo and Dr. Don Ridgell

Date \_\_\_\_\_

*Practice Limited to Prosthodontics*

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 Information -----

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? \_\_\_\_\_

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 \_\_\_\_\_



**Upstate Prosthodontics, L.L.C.**

With Dr. James Pizzo and Dr. Don Ridgell