THOMAS V. ORAZIO, D.M.D.

Patient's Name _____

Date of Birth _____

DENTAL HISTORY

Reason for visit _____

Previous dentist _____ Date last treated ___/___

	YES	NO
Have you ever had any serious problem associated with previous dental treatment?	☐	☐
If yes, explain _____		
Are you having pain at this time?	☐	☐

How often do you brush your teeth? _____ Floss your teeth? _____

What texture brush do you use? Soft ☐ Medium ☐ Hard ☐

What type of brush do you use? Manual ☐ Electric ☐

Do you now have or have you ever had any of the following:

	YES	NO		YES	NO
Gums that bleed while brushing or flossing	☐	☐	Frequent headaches	☐	☐
Gums that are swollen or tender	☐	☐	Sore or popping jaw joints	☐	☐
Pain in any of your teeth when brushing or flossing	☐	☐	Jaws that feel tired and aching	☐	☐
Treatment for periodontal disease (Pyorrhea)	☐	☐	Difficulty in opening or closing	☐	☐
Pain when your teeth come into contact with hot or cold foods	☐	☐	Your teeth ground or the bite adjusted	☐	☐
Orthodontic treatment	☐	☐	Problems with clenching or grinding your teeth	☐	☐
Difficulty wearing dentures/partials	☐	☐	Remove dentures at night	☐	☐
Jaw surgery	☐	☐	Night guard/splint	☐	☐
Ortho retainer	☐	☐	Sleep apnea appliance	☐	☐

Please add anything you feel is important:

The above information is complete, and my permission is given to discuss any portion of it with my physician:

_____ Date _____

Signature of patient or parent/guardian if minor

THOMAS ORAZIO, D.M.D.

Date _____

Patient's full name _____ Birthdate: ____/____/____

Name you prefer to be called _____ Gender: ☐ Male ☐ Female

Whom may we thank for referring you to us? _____

Residence address _____
street city/state zip

Home ph: (___) _____ Cell ph: (___) _____ Work ph: (____) _____

Employer _____ Occupation _____ Email _____

Name of spouse / parent / guardian _____

Previous dentist _____ Last dental visit __/___/ ___ Phone #: (____) _____

Reason for present visit _____

PERSON RESPONSIBLE FOR ACCOUNT

_____ (____) _____
name address city home phone

Relationship to patient _____ Employer _____

Work ph: (____) _____ ext. _____

EMERGENCY NOTIFICATION

Name _____ Relationship _____

Phone (____) _____

DENTAL INSURANCE INFORMATION

Name of employee with insurance: _____
last first middle initial

Name of employer _____

Dental insurance company name: _____

Address of insurance co: _____

ID or social security #: _____ Group #: _____ Birthdate: ____/____/____

IS THERE A 2ND INSURANCE COMPANY? IF SO, PLEASE FILL OUT INFO BELOW

Name of employee with insurance: _____
last first middle initial

Name of employer _____

2nd Dental insurance company name: _____

Address of 2nd insurance co: _____

ID or social security #: _____ Group #: _____ Birthdate: ____/____/____

THOMAS V. ORAZIO, D.M.D.

Patient's Name _____

Date of Birth _____

MEDICAL HISTORY

A complete and thorough history is vital to proper care and safety. We thank you for your cooperation and patience in completing this form. All information is confidential.

PLEASE ANSWER EACH QUESTION

Physician's Name _____ Phone Number _____

Date of last physical exam ___/___ (MO / YR) General Health ☐ Good ☐ Fair ☐ Poor

Pharmacy _____

	YES	NO
Have you ever been hospitalized?	☐	☐
If yes, please briefly explain _____		
Have you been treated for any illness within the past 12 months?	☐	☐
If yes, please briefly explain _____		
Are you now taking any prescribed medications, non-prescription drugs, herbs or supplements?	☐	☐
If yes, please list _____		
Do you require an antibiotic prior to dental treatment per your physician?	☐	☐
If yes, please list _____		
Do you have any allergies?	☐	☐
If yes, please indicate which specific allergies:		

	YES	NO		YES	NO		YES	NO
Aspirin	☐	☐	Codeine	☐	☐	Dental Anesthetics	☐	☐
Erythromyacin	☐	☐	Hay Fever/Seasonal Allergies	☐	☐	Latex	☐	☐
Metals/Jewelry	☐	☐	Penicillin	☐	☐	Tetracycline	☐	☐

List any other allergies or intolerances _____

Do you use tobacco ☐ YES ☐ NO In what form? _____

If yes, usage per day _____ For how many years _____

Do you use marijuana ☐ YES ☐ NO In what form? _____

If yes, usage per day _____ For how many years _____

Women, are you pregnant?	☐	☐
If yes, when is your due date _____		
Are there any inherited diseases or conditions present in your family?	☐	☐
If yes, please briefly explain _____		

PLEASE CONTINUE ON OTHER SIDE

Do you now have or have you ever had any of the following:

	YES	NO		YES	NO		YES	NO
high cholesterol	☐	☐	HIV/AIDS	☐	☐	fibromyalgia	☐	☐
heart attack	☐	☐	depression	☐	☐	thyroid condition	☐	☐
circulatory problems	☐	☐	emphysema	☐	☐	tire easily	☐	☐
heart murmur	☐	☐	asthma	☐	☐	arthritis	☐	☐
heart condition	☐	☐	kidney disease	☐	☐	back/neck issues	☐	☐
high blood pressure	☐	☐	liver disease	☐	☐	artificial heart valve	☐	☐
low blood pressure	☐	☐	hepatitis	☐	☐	artificial joint	☐	☐
jaundice	☐	☐	frequent headaches	☐	☐	fainting/dizziness	☐	☐
anemia	☐	☐	sinus problems	☐	☐	nervous disorders/anxiety	☐	☐
stroke	☐	☐	ulcers	☐	☐	fever blisters/cold sores	☐	☐
rheumatic fever	☐	☐	acid reflux disease	☐	☐	alcoholism	☐	☐
cancer	☐	☐	diabetes	☐	☐	drug addiction	☐	☐
tuberculosis	☐	☐	excess thirst/urination	☐	☐	venereal disease/STD	☐	☐
breathing difficulty	☐	☐	glaucoma	☐	☐	colitis	☐	☐
angina pectoris	☐	☐	chemotherapy	☐	☐	sleep apnea	☐	☐
cosmetic surgery	☐	☐	COPD	☐	☐	mitral valve prolapse	☐	☐
heart surgery	☐	☐	shingles	☐	☐	canker sores	☐	☐
pace maker	☐	☐	radiation therapy	☐	☐	seizures/convulsions/ epilepsy	☐	☐
hemophilia/excessive bleeding	☐	☐	osteoporosis /osteopenia	☐	☐			

Please add anything from your physical or mental health history that you feel is important or is not covered above:

_____

_____

The above information is complete, and my permission is given to discuss any portion of it with my physician:

_____ Date _____

Signature of patient or parent/guardian if minor

NOTES (For Use of Doctor)

DATE	

Tell Us About You...

THE BETTER WE UNDERSTAND YOU, THE BETTER WE CAN SERVE YOU.

Please mark along each scale below to indicate your preferences.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I consider myself well-educated about my dental health	○	○	○	○	○
I like to be presented with options when I require dental treatment	○	○	○	○	○
I have a high level of trust in my previous dental healthcare providers	○	○	○	○	○
I tend to focus on details rather than the big picture	○	○	○	○	○
I prefer long-lasting dental solutions vs temporary fixes	○	○	○	○	○
I prefer to talk in technical terms with my dental healthcare providers	○	○	○	○	○
My insurance benefits largely determine the level of dental care I choose to receive	○	○	○	○	○
Having an esthetically pleasing smile is very important to me	○	○	○	○	○
I generally wait until treatment is urgent vs seeking preventative options	○	○	○	○	○
I hold myself responsible for my own dental health	○	○	○	○	○
I like newer & more modern techniques	○	○	○	○	○
I tend to be fearful or anxious in the dental environment	○	○	○	○	○

THANK YOU.

Use this space to expand upon any points mentioned above.