Southtowns Dental Associates
Dr. Nicholas Rodo

# ***CONFIDENTIAL PATIENT INFORMATION***

DATE:_____ EMAIL:_____

Home Phone_____Cell Phone_____

**PATIENT :** Name:_____
(Last) (First) (Middle)
Address:_____
Place of Employment:_____Occupation:_____
Business Address:_____Business Phone:_____
Date of Birth_____SS#_____Male/Female:_____
Height:_____ Weight:_____ Marital status: Married___Divorced___Widowed___Single___Student_____
Hobbies:_____ _____

**PARENT/SPOUSE:** Name:_____
(Last) (First) (Middle)
Place of Employment:_____Occupation:_____
Business Address:_____ Business Phone:_____
Person Responsible for Account:_____ _____
Whom may we thank for referring you to our office?_____
Has any member of your family been treated in our office? Yes_____No_____Relationship
Why did you choose Dr Rodo?_____
Reason for Visit?_____

**DENTAL HEALTH:** Please circle one: Excellent Good Fair Poor
What priority do you give your dental health (10 being the highest)? 1 2 3 4 5 6 7 8 9 10
Last Dental visit?_____What for?_____Where?_____

**INSURANCE:** Please complete the following confidential information regarding Dental Insurance:
Primary Care Company:_____
MailingAddress:_____
Employee_____SS#_____DOB:_____Group #_____

**MEDICAL HEALTH:** Please circle one: Excellent Good Fair Poor

Physicians Name and Phone number :_____
Last Complete Physical?_____Are you under a Dr. care now?_____If yes, for what reason?_____
_____
Please list any medications, pills, or drugs you are taking and what for:_____
_____
Have you received a blood transfusion? Yes _____No_____ When?_____
Are you subject to fainting spells? Yes _____No_____ Are you pregnant?___ How many weeks?___ Nursing?__
Are you subject to prolonged bleeding? Yes _____No_____

(OVER)

## ***MEDICAL HEALTH*** (con't)

Are you allergic to: Penicillin ?____Codeine?____Local Anesthetics?___ Other Medications?____
List:_____

Please circle if you have or have had any of the following:

| | | |
|---|---|---|
| Heart trouble | Fainting/ Dizziness | Hepatitis B (serum) |
| High Blood Pressure | Stroke | Cancer |
| Low Blood pressure | Diabetes | Recent Weight loss |
| Heart Murmur | Artificial Joints/Hips | Thyroid Disease |
| Rheumatic Fever | Kidney Trouble | Parathyroid Disease |
| Congenital Heart Lesion | Ulcers | X-Ray or Cobalt Tint |
| Artificial Heart Valve | Allergies | Chemotherapy/ Radiation |
| Heart Pacemaker | Asthma | Arthritis/ Gout |
| Heart Surgery | Hay Fever | Glaucoma |
| Mitral Valve Prolapse | Sinus Trouble | Epilepsy/ Seizures |
| Blood Disease | Emphysema | Alzheimer's Disease |
| Anemia | Frequent Cough | Hypoglycemia |
| Chest pain | Lung Disease | Psychiatric Care |
| Shortness of Breath | Liver Disease | Hemophilia |
| Swelling of feet/ ankles/hands | Hepatitis A ( infec) | HIV Positive |

Have you ever had any other serious illness not circled above? Yes?_____No?_____
_____
_____

Do you wish to talk to Dr. Rodo privately about any other problems? Yes_____No_____

I will allow Dr Rodo to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures, and further will allow him permission to discuss my conditions with my physicians and to request medical information form them.

Patients Signature_____

Reviewed by Dr:_____Date_____

I have read my Medical History dated: _____and confirm that it adequately states past and present conditions.

| Date | Exceptions | Patient Signature | Reviewed By: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |