L.N. Passarelli, D.D.S.
K.A. McNally, D.D.S.

PLEASE PRINT Today's Date _____

NAME _____ Date of Birth _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Home Phone _____ Cell _____ Work _____ Email _____

Parent's Name (If Child) _____ Spouse's Name _____

Insurance Company _____ Policy Number _____

Employer _____ Social Security # _____

Business Address _____ Occupation _____

Person Responsible for Account _____ Referred By _____

Physician _____ Physician Phone # _____ Last Physical _____

PATIENT MEDICAL HISTORY

1. Are you under any medical treatment now? Yes No
2. Have you had any operations? If so what? _____
3. Have you ever had a serious accident involving head injuries? Yes No

Please check (✓) if you have any of the following:

- ☐ Anaphylaxis
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Herpes/Fever Blisters
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV/Aids
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Respiratory Disease
- ☐ Rheumatic/Scarlet Fever
- ☐ Stroke
- ☐ Surgical Implants
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer/Stomach Problems
- ☐ Venereal Disease
- ☐ Hospitalized for any reason
- ☐ Other _____

Please describe _____

List any known allergies _____

List any medications _____

4. Have you ever had radiation treatment? Yes No
5. Do you have a history of fainting? Yes No.
6. Have you ever taken Phen/Fen, Redux, or any other diet drugs? Yes No
7. (Women) Are you pregnant? Yes No

PATIENT DENTAL HISTORY

8. Do you have pain in or around the ear? Yes No
9. Do you have any unhealed injuries in your mouth? Yes No
10. Have you had any sore spots or growths in your mouth? Yes No
11. Do you clench or grind your teeth? Yes No
12. Do your gums bleed when you brush? Yes No
13. When was your last full set (16 films) of x-rays? _____
14. Do you have any dental complaints? Please list: _____
15 Have you ever had adverse reactions to: Latex Novocaine

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand the information will be used by the dentist's to help determine the appropriate dental treatment. If there is any change in my medical status I will inform this office.

SIGNATURE _____ Date: _____

X-ray Release Form

I, _____, give authorization for _____ office to release my dental x-rays to the office of _____ for my continued treatment.

_____ Date

_____ Patient name – Print

_____ Patient name – Sign

Date	X-rays Released	Released by
_____	_____	_____
_____	_____	_____
_____	_____	

_____