Welcome

to Excellence In Dentistry and the Office of Dr. Pamela G. Caggiano

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve.

Please complete this form so that we can provide the best care possible for you.

Today's date: ___________________

About You

Name: _____________________________________ I like to be called: ____________________________

Social Security Number: _________________________ Date of Birth: _____________________________

Home Address: ____

City: _________________________ State: ________________ Zip Code: ___________________

Employer: ________________________________ Occupation: _________________________________

Who may we thank for referring you to our office? ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: ______________________________ Spouse's Employer: _______________________

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Special Interests or Hobbies:

____

____

Home Phone: ___________________________ Work Phone: ____________________________

Cell Phone (or Beeper): _______________________ Email: ________________________________

When is the best time to call you? ______________________ and where? ________________________

In case of an emergency, is there someone we can call?

Name: ____________________________ Phone Number: _________________________

Relationship: _______________________

About Your Health

Name of Personal Physician: ____________________________ Phone Number: ______________________

Last visit with physician: ____________________ Current Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke or use chewing tobacco? ☐ Yes ☐ No If yes, how much per day? ____________________

Are you currently taking any prescription or non-prescription medications? ☐ Yes ☐ No

Name of Medication Purpose

____

____

____

Have you had any serious medical problems within the past 5 years? ☐ Yes ☐ No

If yes, please explain:____

____

Have you ever had any surgery including cosmetic enhancements? ☐ Yes ☐ No

If yes, please explain type of surgery and date:____

____

Please CIRCLE the appropriate response

Have you ever had, or been treated for any of the following diseases or medical problems?

Y	N	Heart Attack/ Stroke	Y	N	Heart Murmur/Rheumatic Fever
Y	N	Hepatitis/Jaundice	Y	N	High/Low Blood Pressure
Y	N	Epilepsy/Seizures/Fainting	Y	N	Abnormal Bleeding
Y	N	Cancer/Chemotherapy	Y	N	Kidney Problem
Y	N	Psychiatric Problems	Y	N	Diabetes
Y	N	Tuberculosis	Y	N	Drug/Acohol Abuse
Y	N	AIDS/HIV	Y	N	Anemia
Y	N	Mitral Valve Prolapse	Y	N	Artificial Joint Replacement
Y	N	Fen Phen or other diet medications			

Have you been treated for any other illnesses not listed above? ☐ Yes ☐ No

If yes, please explain:____

____

Do you need to be pre-medicated before dental treatment? ☐ Yes ☐ No ☐ Don't Know

Are you allergic to any of the following?

☐ Erythromycin	☐ Codeine	☐ Latex Rubber
☐ Penicillin	☐ Dental Anesthetic	
☐ Aspirin	☐ Sedatives	

Are you allergic to any other medications? ☐ Yes ☐ No

If yes, please explain: ____

____

For women: Are you pregnant? ☐ Yes ☐ No If yes, how many months? ________________

About Your Smile

Why have you come to the dentist today? ____

____

Many patients consult Dr. Caggiano for a second opinion. Have you seen another dentist for your dental needs? ☐ Yes ☐ No If yes, please explain: ____

____

Date of your last dental visit: ________________ Previous dentist's name: ____________________________

If you could change anything about the appearance of your smile, what would you change?________________

____

If you could easily and safely whiten your teeth, would you be interested? ☐ Yes ☐No

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

Do your gums bleed when you brush? ☐ Yes ☐ No When you floss? ☐ Yes ☐ No

Are your teeth sensitive to ☐ Heat? ☐ Cold? ☐ Sweets? ☐ Biting Pressure?

Have you ever experienced pain in your jaw joint? ☐ Yes ☐ No

Do you grind your teeth ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No

The above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I am aware that this information will be held in the strictest confidence and only be used to improve communication between Dr. Caggiano and myself. I also give permission for Dr. Caggiano to use any photos or models she may take for educational or promotional purposes.

Signature____ Date __________________________