

# Ronald D. Rasi DDS

*Beautiful Smiles*

## WELCOME

*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.*

### ***About You***

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Why did you select our office? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widowed

Spouse Name: \_\_\_\_\_

Special Interest: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

When is the best time to call you? \_\_\_\_\_ Where: \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### ***Responsible Party Information***

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### ***Insurance Information***

#### Primary:

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insured Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Group Number: \_\_\_\_\_

#### Secondary:

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Group Number: \_\_\_\_\_

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## Medical History

### About You

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of personal physician: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Current Health:  Excellent  Good  Fair  Poor

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

Date of last dental visit: \_\_\_\_\_ Reason for this visit? \_\_\_\_\_

Have you ever had any of the following?

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Nervous Disorder     | <input type="checkbox"/> Codeine Allergy     |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Penicillin          |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Growths          | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Sulfa Allergy       |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Hay Fever        | <input type="checkbox"/> Head Injuries        | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatism          |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Murmur     | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> Stomach Problems    |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> HBP              | <input type="checkbox"/> Tumors               | <input type="checkbox"/> Taken Fen-Phen      |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Jaundice         | <input type="checkbox"/> Latex Allergy        | <input type="checkbox"/> Excessive Bleeding  |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Ulcers               |  |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Venereal Disease     | Other _____                                  |

Have you ever been admitted to a hospital or needed emergency care during the past two years? Y N

If yes, please explain: \_\_\_\_\_

Are you now under the care of a physician? Y N If yes, what for? \_\_\_\_\_

Are you taking any medications (including herbal)? Y N

If yes, please list: \_\_\_\_\_

Do you have any health problems that need further clarification? Y N

If yes, please explain: \_\_\_\_\_

Dental History: Have you ever had any complications following dental treatment? Y N

If yes, please explain: \_\_\_\_\_

Many patients consult us for a second opinion. Have you seen another dentist for your needs? Y N

How would you describe the condition of your teeth and gums? \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Are you currently in pain or discomfort with your teeth and gums? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

Previous Dentist Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If you could wave a magic wand and change anything about the appearance of your smile, what would you like to do? \_\_\_\_\_

If you could easily and safely whiten your teeth, would you be interested? \_\_\_ YES \_\_\_ NO

Please RANK the following in the order of which they would KEEP YOU from having dental treatment:

\_\_\_ FEAR of pain \_\_\_ COST of treatment \_\_\_ LACK of concern \_\_\_ MISSING work time

How often do you brush your teeth? \_\_\_\_\_ Floss your teeth? \_\_\_\_\_

Do your gums bleed when you brush your teeth \_\_\_ Yes \_\_\_ No Floss your teeth \_\_\_ Yes \_\_\_ No

Have you ever experience pain in your jaw? \_\_\_ Yes \_\_\_ No Do you grind your teeth? \_\_\_ Yes \_\_\_ No

Have you ever been treated for TMJ symptoms? \_\_\_ Yes \_\_\_ No If yes, explain: \_\_\_\_\_

*The preceding information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and only be used to improve communication between the Doctor and myself.*

Signature \_\_\_\_\_ Date: \_\_\_\_\_