WELCOME!

Foxhallsmiles.com
Joseph A. Catanzano III, DDS

NAME_____M___F____Marital Status _____
Last First M. Int. Suffix

(***If Child***): Parent/Guardian Name_____

How do you wish to be addressed_____Birth Date_____

Eligible for Medicare? _____ Driver's License Number and State_____

Address_____

Employer_____Business Address _____

Occupation_____

Phone: ☐Home (____)_____-_____
☐Cell (____)_____-_____
☐Work (____)_____-_____
☐Emerg (____)_____-_____
☐Email_____(*Please also check the box for your preferred method of contact*)

How did you hear about our office?_____
Other Family Members in this Practice?_____
In Event of Emergency, whom may we notify? _____
What is their contact information?_____

I agree that payment for all services rendered is due at the time of service unless otherwise agreed upon. In the event the amount due is not timely paid, I agree to pay a monthly service charge of 1.5% on any balance due after 60 days and in addition will be responsible for all collection costs including attorney's fees and court costs should collection be necessary.

Release: I authorize Dr. Joseph A. Catanzano III to perform diagnostic procedures and treatment as may be necessary for proper dental treatment. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another health care professional or to the emergency contact as given in the response for "in the event of emergency" space. I attest to the accuracy of the information on this page.

Signature_____Date_____
(patient signature (or parent or guardian)

DENTAL HISTORY

Do you have a specific dental concern? _____ If yes, please explain_____
What are your long term goals for your oral health? _____
What are your expectations of our office? _____
When was your last regular visit?_____ How often are your routine dental exams? _____
Do you think you have active gum disease (gingivitis, periodontitis) or decay?_____
Do your gums ever bleed or are they sore or red?_____
Do you have any loose teeth? _____Do you want to keep your remaining teeth?_____
Do you floss regularly?_____ How often and type of floss?_____
Do you brush regularly?_____ Your routine and how long do you brush: _____
What type of toothbrush (i.e. hand/electric and brand as well as type i.e. soft/medium/hard) and toothpaste do you use?_____
How do you feel about your smile? _____
Is there anything you would like to change about it?_____
Have you ever considered brightening your smile?_____
Have you ever whitened your teeth?_____ If so, how and with what products?_____
Have you ever had orthodontics?_____When_____
Have you ever had any jaw pain or discomfort in your jaw joint?_____
Do you, or has anyone ever told you that you grind or grind your teeth?_____
If so, do you wear an appliance to (i.e. nightguard) to protect your teeth?_____
Do you or has anyone ever told you that you snore or have sleep apnea?_____
Have your past dental experiences always been positive? _____
If not, would you like to explain?_____(Optional)
Name of your previous dentist? _____Last date of visit? _____(Optional)
Reason for changing to our office? _____ (Optional)
Date of last xrays? _____Type of X-rays _____

Tobacco and Alcohol Use History

Tobacco Use: Do you smoke?_____ Do you use smokeless tobacco, snuff, or chew?_____
How much do you smoke or use?_____ How long have you smoked or used it? _____
Have you ever tried to quit? ____Would you be interested in quitting now or in the future?_____
Alcohol Use: Do you drink?_____ If so, how many drinks per week?___For how many years?____
Have you ever noticed any sores or growths in your mouth?_____

PATIENT NAME:_____

MEDICAL HISTORY

Do you have a physician whom you see regularly?_____ If so please provide the following information:
Physician's Name_____ Phone_____ Fax _____
Address_____City_____
(If not, would you like a referral or recommendation? _____)
Date of your last bloodwork tests?_____ Have you ever taken fen-phen? _____
Do you need ***ANTIBIOTIC PREMEDICATION*** prior to your dental appointments? ____
Have you ever been hospitalized or had a major operation?_____Please discuss
_____
Have you ever had a serious injury to your head or neck?_____ Please discuss
_____
Are you taking any medications, pills, drugs, vitamins, or nutritional supplements? Please list:

Medication	Dosage	Reason	Medication	Dosage	Reason

Are you on a special diet?_____
Do you have any allergies to any medications or substances? (Please circle and/or list)
Penicillin Latex Metal Aspirin Codeine Acrylic
*Other*_____

For women: are you - ☐Pregnant/trying to get pregnant ☐Nursing ☐Taking oral contraceptives
(Please also check the box if applicable)

Do you have or have you ever had any of the following? (Please circle all that apply to yourself)

Heart Disease/Surgery*	Bruise Easily/Blood disease	Ulcers	Cortisone Medication
Heart Murmur*	Anemia	Recent Weight Loss	Artificial Joints*
Irregular Heart Beat	Sickle Cell disease	Diabetes (If so, what does	Venereal Disease
Angina/Chest Pain	Hemophilia (bleeding problem)	your blood sugar run?____)	AIDS or HIV Positive
Heart Attack/Failure	Leukemia	Excessive Thirst	Herpes
Congenital Heart Disorder	Recent Blood Transfusion	Hypoglyciemia	Cold Sores/Fever Blisters
Mitral Valve Prolapse	Swelling of Limbs	Liver Disease	Alcohol or Drug Addiction
(with regurgitation)	Lung Disease	Hepatitis A (Infectious)	Stroke
Scarlet Fever	Sinus Trouble	Hepatitis B or C	Convulsions/Epilepsy/Seizures
Rheumatic Fever*	Asthma	Night sweats	Fainting or dizziness
Artificial Heart Valve*	Emphysema	Kidney Problems	Glaucoma
Cardiac Pacemaker*	Tuberculosis	Renal Dialysis*	Tumors or Growths
Pulmonary shunt	Cancer* List type_____	Thyroid Disease	Psychiatric Care
High Blood Pressure	X-ray Treatments (Radiation)	Arthritis/Gout	Alzheimers Disease
Low Blood Pressure	Chemotherapy	Rheumatism	Hives/Rash
Bacterial endocarditis*	Stomach Intestinal Disease		Nervousness

OR
I affirm that I do not and have never had any of the above conditions _____ Date_____

Have you had any other serious illness not checked above? Yes or No. If yes, please discuss:
_____
To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status, or if my medications change, I shall inform the dentist and the staff at the next appointment without fail.

Signature_____Date_____
patient signature (or parent or guardian)
MEDICAL HISTORY FORM Reviewed by Dr. Catanzano_____Date_____