

# WELCOME TO OUR OFFICE

James E. Fitzgerald, DDS, Inc.  
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415.468.5353  
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## Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
SS# \_\_\_\_\_ Birth Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Check appropriate box: Minor  Single  Married  Separated  Divorced  Widowed

Whom may we thank for sending you/How did you find us? \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party Information (if different from above)

Name \_\_\_\_\_ Date \_\_\_\_\_  
SS# \_\_\_\_\_ Birth Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

For your convenience we offer the following methods of payment. Please check the option you prefer.  
Payment in full is due at each appointment.

Cash  Personal check  Credit Card  I wish to discuss the office's payment policy

## If Student:

Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Full Time  Part Time

## Primary Dental Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Insured: Self  Spouse  Child   
SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you have additional dental insurance? If yes, complete the following:

## Secondary Dental Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

# PATIENT MEDICAL HISTORY

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you under medical treatment now? Yes  No  If yes, please explain \_\_\_\_\_
  
2. Has a physician recommended that you take antibiotics prior to your dental treatment? Yes  No
  
3. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes  No  If yes, please explain \_\_\_\_\_
  
4. Are you on a special diet? Yes  No  If yes, please explain \_\_\_\_\_
  
5. Are you taking any medication(s) including non-prescription medicine? Yes  No  If yes, what medication(s) are you taking? \_\_\_\_\_
  
6. Have you ever taken Fen-Phen/Redux? Yes  No
  
7. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Yes  No
  
8. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes  No
  
9. Do you use tobacco? Yes  No
  
10. Do you use controlled substances? Yes  No
  
11. Are you allergic to or have you had any reactions to the following:

Local Anesthetics (e.g. Novocain)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Penicillin or any other antibiotics	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sulfa Drugs	Yes <input type="checkbox"/> No <input type="checkbox"/>
Barbiturates	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sedatives	Yes <input type="checkbox"/> No <input type="checkbox"/>
Iodine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Aspirin	Yes <input type="checkbox"/> No <input type="checkbox"/>
Latex Rubber	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any Metals (e.g. nickel, mercury, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other	Yes <input type="checkbox"/> No <input type="checkbox"/>

If yes, please explain \_\_\_\_\_
  
12. Do you have a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)? Yes  No
  
13. Women Only:

Are you pregnant or think you may be pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you nursing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you taking oral contraceptives?	Yes <input type="checkbox"/> No <input type="checkbox"/>

# Do you, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B/C	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/ Seizures	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Rash	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/ Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/ Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/ Failure	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors/ Growths	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/ Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/ Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>				Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>									

Have you ever had any serious illness not listed above? Yes  No  If yes, please explain \_\_\_\_\_

Comments \_\_\_\_\_

# PATIENT DENTAL HISTORY

Name of previous dentist \_\_\_\_\_

Location \_\_\_\_\_ Date of last exam \_\_\_\_\_

1. Do your gums bleed while brushing or flossing? Yes  No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes  No
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes  No
4. Do you feel pain in any of your teeth? Yes  No
5. Do you have any sores or lumps in or near your mouth? Yes  No
6. Have you have any head, neck, or jaw injuries? Yes  No
7. Have you ever experienced any of the following problems in your jaw:  
Clicking Yes  No   
Pain (joint, ear, side, face) Yes  No   
Difficulty in opening or closing Yes  No   
Difficulty in chewing Yes  No
8. Do you have frequent headaches? Yes  No
9. Do you clench or grind your teeth? Yes  No
10. Do you bite your lips or cheeks frequently? Yes  No
11. Have you ever had any difficult extractions in the past? Yes  No
12. Have you ever had any prolonged bleeding following extractions? Yes  No
13. Have you had any orthodontic (braces) treatment? Yes  No
14. Do you wear dentures or partials?  
If yes, date of placement \_\_\_\_\_
15. Have you ever received oral hygiene instructions regarding the care of your teeth or gums? Yes  No
16. Have you ever received periodontal (gum) scaling or surgery?  
If yes, when? \_\_\_\_\_ Yes  No
17. Do you like your smile? Yes  No

## AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize James E. Fitzgerald DDS Inc. to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

\_\_\_\_\_  
Signature of patient (or parent/guardian if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_

## Additional Statement

Not all services are covered by insurance. In the event your insurance plan determines a service is not covered, you will be responsible for the complete charge. Our staff cannot guarantee your eligibility and coverage. Insurance rules and limits vary with insurance plans.

If the dentist determines there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I therefore authorize the dentist to contact my physician if necessary.

By consenting to treatment, you understand that the use of anesthetic agents embodies certain risks. If you have any concerns about potential complications, please do not hesitate to ask.

## Late Cancellations

Appointments cancelled less than 24 hours in advance will incur a late cancellation fee of \$25.00 per 30 minutes of scheduled appointment time.

## Late Charges

If you do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the unpaid balance will be assessed monthly. Please note that failure to keep this account current may result in us being unable to provide additional dental services, except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, the patient will be responsible for collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding balances.

***I certify that I have read and understand the above information to the best of my knowledge.***

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\_\_\_\_\_  
Signature of patient (or parent/guardian if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_