



**LOUIS F. CLARIZIO, DDS PA**  
 ORAL SURGERY & DENTAL IMPLANT CENTER

**PATIENT INFORMATION**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Email \_\_\_\_\_

Mailing Address \_\_\_\_\_  
 Street \_\_\_\_\_  
 Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_

Student? \_\_\_\_\_ Name of School \_\_\_\_\_ Town of School \_\_\_\_\_ State of School \_\_\_\_\_

Employer's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_  
 Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referred by \_\_\_\_\_

Dentist \_\_\_\_\_ Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Cardiologist \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber's Name (Mr., Mrs., Ms.) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Subscriber's Address \_\_\_\_\_

Relationship to Patient \_\_\_\_\_  
 (Self, Spouse, Child, Other) \_\_\_\_\_ Employer \_\_\_\_\_

Dental Insurance \_\_\_\_\_  
 Name of Company \_\_\_\_\_ Mailing Address \_\_\_\_\_  
 ID # \_\_\_\_\_ Group # \_\_\_\_\_

Medical Insurance \_\_\_\_\_  
 Name of Company \_\_\_\_\_ Mailing Address \_\_\_\_\_  
 ID # \_\_\_\_\_ Group # \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name (Mr., Mrs., Ms.) \_\_\_\_\_ Home Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_  
 Street \_\_\_\_\_  
 Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_  
 Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**I UNDERSTAND THAT I AM RESPONSIBLE FOR SERVICES RENDERED TO MYSELF OR MY DEPENDENT AT THE TIME OF SERVICE, AND THAT ANY FINANCIAL ARRANGEMENTS WILL BE DISCUSSED PRIOR TO TREATMENT.**

SIGNATURE OF RESPONSIBLE PARTY \_\_\_\_\_

DATE \_\_\_\_\_

(Over)

# HEALTH QUESTIONNAIRE

1. Are you in good health? Yes No

2. Are you now under the care of a physician? Yes No

If so, what is the condition being treated?

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3. Have you been hospitalized or had a serious illness in the last five years? Yes No

If so, what was the problem?

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4. CIRCLE any of the following which you have had or have at present:

Heart Disease or Attack

Angina

Stroke

High Blood Pressure

Heart Murmur

Rheumatic Fever

Mitral Valve Prolapse

Artificial Heart Valve

Artificial Joint

Epilepsy or Seizures

Stomach Ulcers

Cancer - What type \_\_\_\_\_

Chemotherapy

Radiation

Emphysema

Tuberculosis

Asthma

Sinus Trouble

Allergies

Thyroid Disease

Arthritis

Other \_\_\_\_\_

Diabetes

Venereal Disease:

(Syphilis, Gonorrhea)

HIV/AIDS

Hepatitis C

Anemia

Kidney Trouble

Liver Disease

Hemophilia

Glaucoma

5. List any allergies including latex, epinephrine or other drugs \_\_\_\_\_

6. List any medications you take including prescription and over the counter medications \_\_\_\_\_

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7. PLEASE CHECK CONDITION(S) THAT APPLY TO YOU:

**Difficult veins** when having bloodwork or I.V.'s

**History of taking a lot of antibiotics, even as a child**, for strep, bronchitis, ear infections, sinus infections, Lyme disease, or any other reason.

Premedicate with antibiotics prior to dental appointments

Sleep Apnea

History of taking medications for acne (Doxycycline or Tetracycline)

Clicking or popping of jaw joint

Grind or clench your teeth

Smoker

Chew / Tobacco

Women: pregnant or nursing?

Gag reflex

8. PLEASE CHECK MEDICATIONS THAT APPLY, OR HAVE APPLIED TO YOU IN THE PAST:

**Bisphosphonates**, orally or by infusion (**Bone Strengtheners**)(i.e. Fosamax, Boniva, Actonel, Reclast, Zomeda, Aredia)

When did you start? \_\_\_\_\_ How long did you take them? \_\_\_\_\_ When did you stop? \_\_\_\_\_

Insulin? How often daily \_\_\_\_\_

Steroids (i.e. Prednisone)

Blood thinners (i.e. Coumadin, Warfarin, Plavix, Aspirin, 81 mg or 325 mg)

Inhaler? How often used \_\_\_\_\_

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

Revised \_\_\_\_\_ Date \_\_\_\_\_

Revised \_\_\_\_\_ Date \_\_\_\_\_

Reviewed By \_\_\_\_\_ Date \_\_\_\_\_