Calcaterra Family Dentistry
Nicholas Calcaterra DDS
Carla Calcaterra DDS
www.orangectdentist.com (203) 799-2929

# Medical History

Date: _____Name: _____ Date of Birth:_____ Gender: M F

Emergency Contact Name:_____ Relation:_____

Emergency Contact Primary Phone #:_____ h /c /w Secondary #:_____ h /c /w

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Main Physician's Name:_____Phone#:_____

Do you smoke or use tobacco in any other form? YES NO If yes, how much: _____

For WOMEN: Are you Pregnant? YES NO Are you nursing? YES NO Are you taking birth control pills? YES NO

Have you ever been advised by a physician that you should premedicate with antibiotics for dental treatment? YES NO

**Have you ever or do you now have any of the following medical conditions? Please circle.** (Y=Yes, N=No)

Y N Abnormal Bleeding
Y N Obstructive Sleep Apnea
Y N Sickle Cell Disease/Traits
Y N Hemophilia Type?_____
Y N Gastric Ulcers
Y N Arthritis
Y N Osteoporosis
Y N Artificial Joints When?_____
Y N Cancer/Chemotherapy
Y N Radiation Treatment
Y N TMJ/TMD
Y N Epilepsy / Seizures
Y N Thyroid Problem
Y N Celiac Disease/Gluten Intolerance

Y N High Blood Pressure
Y N Heart Disease
Y N High Cholesterol
Y N Stroke When?_____
Y N Heart Attack When?_____
Y N Heart Surgery When?_____
Y N Cardiac Stent When?_____
Y N Pacemaker When?_____
Y N Heart Murmur
Y N Congenital Heart Disease / Prosthetic Cardiac Valve/ Previous Infective Endocarditis/ Palliative Shunt or Conduit
Y N Liver Disease

Y N Alcohol/Drug Abuse
Y N Hepatitis Type? _____
Y N HIV / AIDS
Y N Tuberculosis (TB)
Y N Herpes/Fever Blisters/Cold sores
Y N Kidney Problems/Disease
Y N Psychiatric Problem
Y N Diabetes Type I or II?
Y N Asthma
Y N Emphysema
Y N Bisphosphonate use? Oral or IV? (e.g. Fosomax, Actonel, Boniva)

Any other medical condition(s)? YES NO If yes, please explain:_____

_____

List all prescription and over-the-counter medications: _____

_____

Do you have any allergies to medications? YES NO If yes, please circle:

| | | | | | |
|---|---|---|---|---|---|
| Penicillin | Keflex/Cephalosporins | Latex | Motrin/Advil (ibuprofen) | Aspirin | Dental Anesthetics |
| Tetracycline/Doxycline | Z-Pack (azithromycin) | Codeine | Gluten | | |

Please list any other drugs/materials to which you are allergic: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information is protected according to HIPAA regulations and it is my responsibility to inform my provider of any changes in my medical status.

Patient/Guardian Signature:_____ Date:_____

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For Office Use Only:

Reviewed by: _____ Date: _____

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# Patient Information Form

Patient Name: _____ Birthdate: _____

Home Address: _____ Town/City: _____

State: _____ Zip: _____ Email: _____

Primary Phone: _____ h/c/w Secondary Phone: _____ h/c/w

SSN: _____ Marital Status: _____ Gender: M F

Occupation: _____ Employer:_____

How did you hear about us: _____

## Dental Insurance Information (only if you have insurance)

Subscriber's Name: _____ Primary Phone #: _____

Home address: _____ City: _____ State: _____ Zip:_____

Subscriber's Date of Birth: _____ Insured's SSN: _____

Subscriber's Insurance ID#:_____ Subscriber's Employer:_____

Insurance Company:_____

## Secondary Dental Insurance Information (only if you have two insurances)

Subscriber's Name: _____ Primary Phone #: _____

Home address: _____ City: _____ State: _____ Zip:_____

Subscriber's Date of Birth: _____ Insured's SSN: _____

Subscriber's Insurance ID#:_____ Subscriber's Employer:_____

Insurance Company:_____

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## Authorization to Pay Benefits and to Release Information

I hereby authorize payment directly to the above named dentist(s) of the dental benefits otherwise payable to me.

I hereby release the above named dentist to provide any insurance company(s), claims administrator(s) and consulting health care professionals information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of coverage of the policy contract.

_____

**Patient Name (printed)**

_____ _____

**Patient or Authorized Person Signature** **Date**

## Consent to Office Policies

I am aware that Calcaterra Family Dentistry cannot guarantee my receipt of benefits from the insurance (if any) company for treatment. I understand that any portion not covered by my insurance (if any) is my responsibility and any such balance is due payable upon the date services are rendered, unless written financial arrangements have been made. My signature confirms that I will assume full responsibility for my dependents' and my balance. I understand and agree that if my account is turned over for collection, I will be responsible for reasonable attorney fees and court costs.

Scheduled appointments are specific times that our clinical and administrative staff have dedicated to you. Appointment cancellation without at least 24 hours notice does not give us the time to fill that appointment time.

I understand that my failure to cancel scheduled appointments without ***at least 24 hours notice*** will result in a charge as posted in the reception area. The broken appointment charge as of this revision of this document is $75.00.

I, the undersigned, acknowledge and agree with the above office policies.

_____

**Patient Name (printed)**

_____ _____

**Patient or Authorized Person Signature** **Date**

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## Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned, have received and reviewed a copy of the Notice of Privacy Practices of Calcaterra Family Dentistry.

Copies of the Notice of Privacy Practices are available online at www.orangectdentist.com as well as at our front desk.

_____

**Patient Name (printed)**

_____ _____

**Patient Signature** **Date** **If minor, Signature of Parent or Guardian**