Patient Name _____ Date_____
Sex____ Age____ S.S.# _____ Date of Birth _____

Home Address _____
_____
City/State/Zip _____
Home Telephone ( )_____
Cell Telephone ( )_____
Email _____
Referred By _____
Business Name_____
Address _____
City/State/Zip _____
Business Telephone ( )_____
Insurance Co. _____
Phone _____ Group Number _____
Employer _____ Effective Date _____
Who is responsible for your bill? _____

MICHAEL LIBERTO, D.D.S.

ORTHODONTICS• IMPLANTS• COSMETIC & FAMILY DENTISTRY

PATIENT INFORMATION FORM

In the event of an emergency, Please Contact :
Name _____
Relationship
Address_____
_____
Home Telephone ( )_____
Business Telephone ( )_____

MEDICAL & DENTAL HISTORY

Please be assured all medical information will be held in the strictest confidence

Family Physician _____
Address _____
_____
Phone ( )_____ Last Physical _____

	YES	NO
Do you have any current health problems?	☐	☐
Are you under a physician's care now? For what? _____	☐	☐
Are you currently taking any medication? If yes, what? _____	☐	☐
Are you pregnant?	☐	☐
Do you smoke?	☐	☐
Have you contracted any of the following diseases:	☐	☐
AIDS, herpes, mononucleosis, respiratory illnesses,	☐	☐
Hepatitis A, hepatitis B?	☐	☐
Have you gained 10 or more pounds in the last six months?	☐	☐
Did you have a blood transfusion prior to March 1985?	☐	☐
Have you had sores in or around your mouth or on other parts of your body in the past which occasionally return?	☐	☐

Last Dental Exam Date _____

	YES	NO
Are you missing any teeth?	☐	☐
Do you wear dentures? (partial or full)	☐	☐
Are you unhappy with your dentures?	☐	☐
Would you like to know more about permanent replacements?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Do your gums bleed, or feel tender or irritated?	☐	☐
Are your teeth sensitive to hot, cold sweets or pressure? (please circle)	☐	☐
Are you aware of grinding or clenching your teeth?	☐	☐
Do you have headaches, earaches or neck pains?	☐	☐
Are you unhappy with the appearance of your teeth?	☐	☐
Do you have discolored teeth that bother you?	☐	☐
Would you like your smile to look better or different?	☐	☐
Do you have any trouble eating or digesting food?	☐	☐

Circle any of the following which you had or have present:

Heart failure	Cosmetic Surgery	Venereal Disease (syphilis, gonorrhea, etc.)
Heart disease or attack	AIDS (HIV)	
Angina Pectoris	Hepatitis A (infectious)	
High Blood Pressure	Hepatitis B (infectious)	Bruise easily
Heart Murmur	Liver Disease	Tuberculosis (TB)
Rheumatic Fever	Yellow Jaundice	Asthma
Congenial Heart Lesions	Blood Transfusion	Hay Fever
	Drug Addiction	Sinus Trouble
Scarlet Fever	Hemophilia	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or seizures	Thyroid Disease
Heart Surgery	Fainting or Dizzy	X-ray or Cobalt Treatment
Artificial Joints (hip, knee)	Spells	
	Nervousness	Arthritis
Anemia	Psychiatric Treatment	Rheumatism
Stroke	Sickle Cell Disease	Cortisone Medicine
Kidney Trouble	Glaucoma	Pain in Jaw Joints
Ulcer	Chemotherapy (cancer, Leukemia)	Alcoholism
		Bleeding

Are you allergic or have you reacted aversely to any of the following medications?

Aspirin	Nitrous Oxide	Erythromycin
Codeine	Novocain	Penicillin
Percodan	Valium	Other: _____

Are you aware of being allergic to latex? YES NO

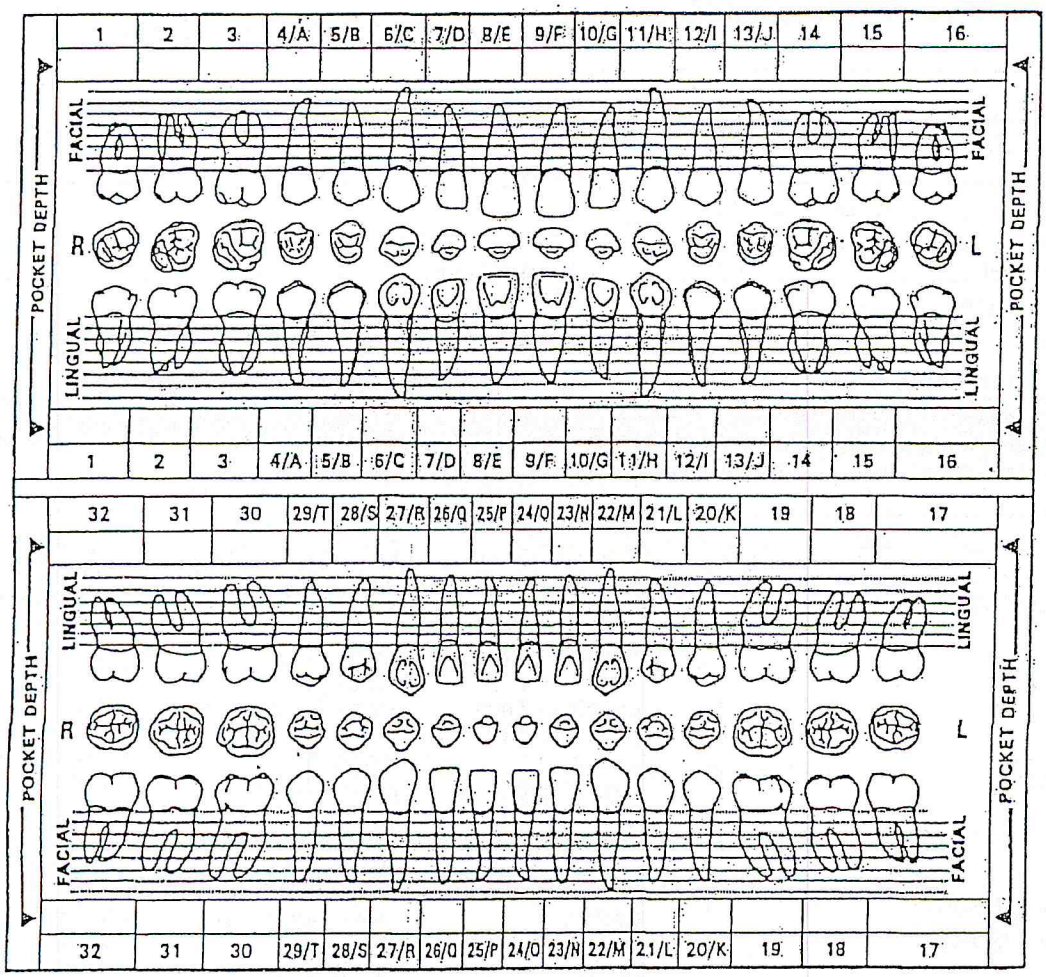
Is there any other medical or dental information that you feel we should know about?
If yes, please list: _____

I Certify that the answers to these questions are correct to the best of my knowledge:

Signature_____ Date_____

CHIEF COMPLAINT _____ BLOOD PRESSURE ____/____ PULSE _____ RESP _____ TEMP _____

MEDICAL ALERT



REVIEWED MED HX _____

EXTRAORAL _____

HEAD & NECK _____

TMJ _____

INTRAORAL _____

ORAL CANCER _____

ORAL HYGIENE _____

PLAQUE _____ CALCULUS _____

SEXTANT SCORE | PERIODONTAL SCREENING & RECORDING. MONTH DAY YEAR

PERIODONTAL TYPE I II III IV

TX _____

OCCLUSION _____

EXT's _____

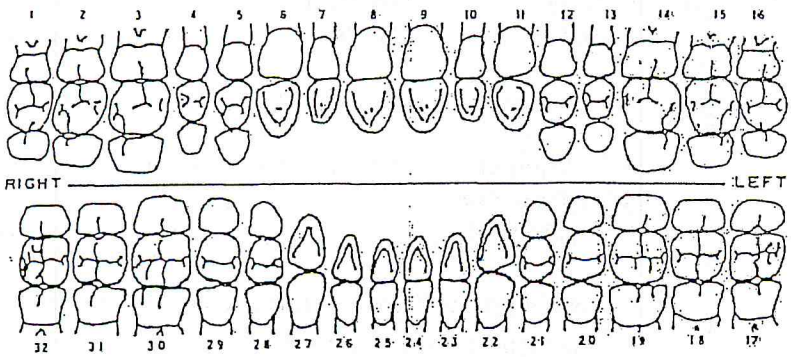
IMPLANTS _____

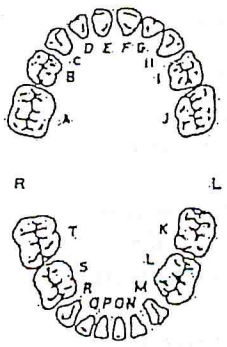
COSMETICS _____

ORTHO _____

NOTES _____

INITIAL EXAM DATE _____





PERIO TX _____

REVIEWED MED HX _____

NOTES _____

NOTES _____