YOUR SYRACUSE

FAMILY DENTIST

VINCENT D. DIMENTO DMD

WELCOME TO OUR PRACTICE

Thank you for choosing us. Our goal is to provide you with quality dental care and personal attention to ensure your continued good health. We are committed to providing our patients with state of the art care in a comfortable; relaxing and friendly environment. It is our goal to conduct a comprehensive review of your dental records in order to determine the proper treatment for you. After we finish gathering all pertinent information, Dr will review with you all findings. We will discuss all treatment in detail, including benefits, risks, and alternatives at a separate consultation visit. It is our desire for you to leave our office with a full understanding of your treatment and with all questions answered. Once we have determined the best treatment plan, our staff will assist you with any appointment and scheduling needs and attempt to assist you with any insurance questions you may have.
We look forward to meeting you & thank you for choosing us for your dental health needs ☺

REMINDER we will need any **current** X-rays you may have from a previous dentist, **prior to seating you**. (Current is <1yr old for Bite Wings or <3yr for Panoramic Film or <3 yr for Full Mouth Series).

Just a couple of items to take care of: Please fill out all the following paperwork. **(HIPPA** and **Financial Policy you will sign in computer in office)** in addition we would like you to fill out questions below. Thank you & have a great day ☺

NAME: _____ DATE: _____

DENTAL HISTORY

May we ask who referred you to our office

_____

Reason for today's visit

_____

Former Dentist_____ Date of last dental visit_____ Date of last X-rays_____

Immediate Dental Concerns_____

Long Term Dental Concerns_____

Your Dental Goal

Patient Information:

First Name: _____Last Name: _____Middle Initial: _____

Preferred Name: _____

Address: _____ Apt # _____

City, State, Zip: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Sex: ○ Female ○ Male Birth date: _____ Social Security # _____

E-mail: _____

Patient is: □ Responsible Party □ Policy Holder

Preferred Pharmacy: _____ Referred By: _____

Responsible or Insured Party: (if different from the patient above)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Apt # _____

City, State, Zip: _____

Home Phone: _____Work Phone: _____ Cell Phone _____

Birth date: _____ Social Security # _____

○ **Responsible Party is Policy Holder for Patient** ○ **Primary Policy Holder** ○ **Secondary Policy Holder**

Primary Insurance Information:

Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insurance ID# _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Secondary Insurance Information:

Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insurance ID# _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Time 3:48 PM

Your Syracuse Family Dentist

Date 5/2/2017

Eaglesoft Medical History Updated 5-2-17(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Other			

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____