MEDICAL HISTORY **DATE:**_____

First Name_____MI____Last Name_____
Street Address_____City_____State_____Zip Code_____
Home Phone #_____Work Phone #_____Cell Phone#_____
Email Address:_____
To Confirm appointments, how is the best place to contact you?
Cell____ Text____ Work____ Home____ Email____

Date of Birth _____Sex_____ Height_____Weight_____Single_____Married_____
Social Security #_____Name of Spouse_____
Your Occupation_____Place of Employment_____
Closest Relative_____Phone Number_____

Do you have dental insurance?____If yes, name of company_____
Are you the policy holder?_____ If not, name of policy holder_____
Social Security # of policy holder_____Date of birth of policy holder_____

Who referred you to Dr. Nicoletti? _____
Why are you changing dentists?
Change in dental insurance____ Referral_____ Location/Convenience___ Not satisfied with previous dentist___
Other_____

In the following questions, please check or yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

YES NO

☐ ☐ Are you in good health?
☐ ☐ Has there been any change in your general health within the past year?
When was your last physical exam? _____
☐ ☐ Are you now under the care of a physician?
If so, what is the condition being treated? _____
Name, address, phone# of my physician is_____
_____
☐ ☐ Have you had **ANY** surgeries? Please list all_____
_____
☐ ☐ Have you been hospitalized or had a serious illness within the past five (5) years?
If so, what was the reason?_____
Do you have or have you had any of the following conditions?
☐ ☐ Damaged heart valves or artificial heart valves
☐ ☐ Congential heart lesion
☐ ☐ Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) (please circle)
☐ ☐ Do you have pain in chest upon exertion?
☐ ☐ Are you ever short of breath after mild exercise?
☐ ☐ Do your ankles swell?
☐ ☐ Do you have a heart Murmur?
☐ ☐ Do you get short of breath when you lie down, or do you require extra pillows when you sleep?
☐ ☐ Do you have a cardiac pacemaker?
☐ ☐ Allergy
☐ ☐ Sinus trouble
☐ ☐ Asthma
☐ ☐ Thyroid disorders
☐ ☐ Hives or skin rash (please circle)
☐ ☐ Fainting spells or Seizures (please circle)

Next page

YES NO

- ☐ ☐ Diabetes
- ☐ ☐ Do you have to urinate (pass water) more than six times a day?
- ☐ ☐ Are you thirsty much of the time?
- ☐ ☐ Does your mouth frequently become dry?
- ☐ ☐ Hepatitis (A, B or C), jaundice or liver disease (please circle)
- ☐ ☐ Arthritis
- ☐ ☐ Inflammatory rheumatism (painful swollen joints)
- ☐ ☐ Stomach Ulcers
- ☐ ☐ Kidney trouble
- ☐ ☐ Tuberculosis
- ☐ ☐ Do you have a persistent cough or cough up blood?
- ☐ ☐ Low blood pressure
- ☐ ☐ Have you had abnormal bleeding associated with previous extractions, surgery or trauma?
- ☐ ☐ Do you bruise easily?
- ☐ ☐ Have you ever required a blood transfusion?
  If so, explain the circumstances_____
- ☐ ☐ Do you have any blood disorder such as anemia?
- ☐ ☐ Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck?

Are you taking any of the following?

- ☐ ☐ Antibiotic or sulfa drugs
- ☐ ☐ Anticoagulants (blood thinners)
- ☐ ☐ Medicine for high blood pressure
- ☐ ☐ Cortisone (steroids)
- ☐ ☐ Tranquilizers
- ☐ ☐ Antihistamines
- ☐ ☐ Aspirin
- ☐ ☐ Insulin, tolbutamide (Orinase) or similar drug
- ☐ ☐ Nitroglycerin
- ☐ ☐ Oral contraceptive or other hormonal therapy
- ☐ ☐ Are you taking any other drug or medicine not listed?
  If so, what?_____

Are you allergic or have you reacted adversely to:

- ☐ ☐ Local anesthetics
- ☐ ☐ Penicillin
- ☐ ☐ Other antibiotics_____
- ☐ ☐ Sulfa drugs
- ☐ ☐ Barbiturates, sedatives, or sleeping pills
- ☐ ☐ Aspirin
- ☐ ☐ Iodine
- ☐ ☐ Codeine
- ☐ ☐ Other narcotics_____
- ☐ ☐ Other medication not listed _____
- ☐ ☐ Have you had any serious trouble associated with any previous dental treatment? If so, explain_____
  _____
- ☐ ☐ Do you have any disease, condition, or problem not listed above that you think I should know about? (Example: HIV, STD)
  If so, explain_____
- ☐ ☐ Are you employed in any situation which exposes you regularly to x-rays or other ionizing Radiation? If so, explain_____

Next page

YES NO

☐ ☐ Have you had any artificial joint replacement? (Example: hip replacement, knee replacement)

☐ ☐ Have you been told by a doctor that you need to take antibiotics (**premedicate)** before dental procedures?

Women

YES NO

☐ ☐ Are you pregnant?

☐ ☐ Do you have any problems associated with your menstrual period?

☐ ☐ Are you nursing?

CHIEF DENTAL COMPLAINT:

_____

_____

_____

_____

_____

_____

SIGNATURE OF PATIENT

_____

SIGNATURE OF DENTIST

ADA

AMERICAN DENTAL ASSOCIATION

GARY J. NICOLETTI, D.M.D. 130 Kinderkamack Road, Suite 208, River Edge, NJ 07661
Phone # (201) 488-0200 Fax # (201) 488-9449 Email Address: drgarynicoletti@optimum.net

PAYMENT POLICY

You are responsible for 100% of any and all fees for services provided. All payments are due when services are rendered (except for certain insurance companies). We accept VISA, Master Card, Discover, American Express, personal checks, money orders and cash. If you have insurance, we will gladly process your claim for you, but understand that any uncovered amounts, deductibles, co-payments, etc. are your responsibility and are due the day of service. If you are unable to pay in full at the time of service, a payment plan must be agreed to ahead of time with Dr. Nicoletti. Any payment not received upon receipt of service, or any late installments of a payment plan will result in a **monthly** finance charge of 3% (24% A.P.R.) or $5.00 minimum (whichever is greater) until the balance is paid in full. You agree that after 60 days of no payment, your account will be turned over to a collection attorney. You also agree that any and all attorney fees and legal costs incurred to collect will be in addition to the balance owed and shall be paid by you upon demand.

UNATTENDED CHILDREN

As you know, we are a Family Dental Practice. Children are always welcome as patients. However, we do not provide a babysitting service. Due to the fact that our insurance coverage does not cover the office as a "day care" facility, accidental destruction of property due to an unattended child, our office requests that this situation is avoided. Therefore, children are not allowed in the operatories nor are they to be left unattended in our waiting room.

STERILIZATION

All instruments are either disposable, heat sterilized by autoclave (as used in hospitals) or by a comparable method approved by the American Dental Association and the Organization for Health and Safety. Any further questions regarding our sterilization procedures are welcome. In addition you will notice that all our clinical staff wear scrubs. All the above mentioned sterilization and sanitary methods implemented within this office are for our patient's safety as well as our own.

_____

PATIENT SIGNATAURE

OFFICE POLICY

APPOINTMENTS: Please understand there is a method to our scheduling of appointments. When we book appointments for you, you book our time, facilities, and attention. Every effort is made to keep on schedule so that no one is "rushed." In good faith, we respectfully ask patients to be prompt and to keep their appointments.

Our standard office policy regarding appointments is as follows:

1. We try to remind patients by telephone, text and/or e-mail prior to the appointment, but understand that this is just a "courtesy" reminder. We also send reminder post cards at the beginning of the month for patients coming in or due to see the hygienist.

2. If we are unable to contact you, your appointment card (or appointment made over the phone or e-mail) should adequately serve as your confirmation and implies your obligation to be present at the correct time.

3. If you need to change an appointment, we request at least **72 hours notice (NOT including weekends and/or holidays)** to avoid a charge for "LOST" time.

4. Exceptions to this policy can be determined only on an individual basis according to circumstances.

Charges for "LOST TIME" include not showing up at all, no telephone call, no e-mail and/or cancellation of the appointment **without 72 hours notice (NOT including weekends and/or holidays.** There will be a **$100.00 - $110.00** per hour charge billed according to the amount of time allotted for your appointment.

I have read the above office policy, and understand my obligations when an appointment is made with Dr. Gary Nicoletti.

PATIENT NAME (PRINT) **PATIENT NAME (SIGNATURE)**