Personal History

Patients Name_____ Soc.Sec # _____ Date of Birth_____

Home Address_____ Home Phone_____
Street & Number, Town, State, Zip Code — Area Code& Number

Occupation or Name of School_____ Employer_____

Employer Address_____ Work Phone_____
Street& Number Town State Zip Code — Area Code & Number

Who referred you to this office? _____Who accompanied you to office? _____Relationship_____

Have you ever been to this office before? _____ as a patient or accompanying a patient? _____ Who? _____

Person Responsible for professional fees_____ Relationship to patient self, spouse, child, other_____

Responsible Person Address _____ Soc.Sec#_____
Street &Number Town State Zip Code

Responsible Person Employer & Address_____
Street & Number Town State Zip Code

Do you have insurance that may cover a portion of this fee? No___ Yes___ Don't Know____ (Medicare does not pay for teeth)

Name of Company_____ Policy Number_____ Group Number_____

Name of Insured_____ Soc. Sec # _____ Date of Birth_____

Additional Insurance Company _____Policy Number_____ Group Number_____

Name of Insured _____Soc. Sec. #_____Date of Birth_____

Name of Insured_____ Their Address_____

Relationship to insured self, spouse, child, other_____ Today's Preferred method of payment Cash, Check, Visa, MasterCard, Discover, Amex

Why are you here? _____

How long has it bothered you? _____

Who is your Dentist? _____

In General, How do you feel? _____

Who is your Physician? _____

When were you there last? _____

Have you had a Recent (2 years) Operation? _____

What Drugs or Medicines are you taking now? _____

_____

Are you Allergic to anything? _____

Do any medicines make you sick? _____

When did you last eat or drink? _____

How much do you smoke? _____

Age____ Sex M__ F__ Approx Weight_____ lbs Pregnant?_____

Medical History

Did you ever have:	YES	NO	Not Sure
Asthma	____	____	____
Tuberculosis	____	____	____
Lung Disease	____	____	____
Osteoporosis	____	____	____
Heart Attack	____	____	____
Heart Disease	____	____	____
By-Pass Surgery	____	____	____
Epilepsy	____	____	____
Diabetes	____	____	____
High Blood Pressure	____	____	____
Thyroid Disease	____	____	____
Liver Disease	____	____	____
Hepatitis	____	____	____
Jaundice (yellow)	____	____	____
Clotting Disease	____	____	____
Blood Disease	____	____	____
Kidney Disease	____	____	____
Other Disease	_____		

Release

I authorize the release if any medical/dental information necessary to process the insurance claim. I authorize payment of benefits to Dr. Vitale for services described on claim forms. I certify the above information is correct to the best of my knowledge. I understand that 1.5% interest is charged on accounts due over 60 days. I understand that patient/ responsible person can be held responsible for collection costs and additional fee of one-third(1/3) of the balance due for collection agent/ attorney fees, and further additional billing and court cost may be assessed.

_____ _____

ignature of Patient or Responsible Party — Date