MICHAEL BARNO, DMD
CHRIS ROBNETT, DMD
NICOLE ANDREINI, DDS, MS

Today's Date __________________________ **Social Security #** _______________________________

Name ____Preferred Name________________________________
Last First MI

Date of Birth __________________________________ **Gender** ________________ **Circle one**: Single Married Other

Address ____ **City**____________________ **State** ________________**Zip**__________

Phone (H) _____________________ C)____________________ (W)___________________**Email** __________________________________

Employer ____ **Occupation** __________________________________

Person Responsible for Account ____ **Relationship** __________________________

If married, name of spouse ____ **Spouse's date of birth** _________________

Emergency Contact Name____**Phone Number**_______________________

Reason for today's visit? ____

Whom may we thank for referring you? ____

Has any member of your family been treated here previously?____

Dental Insurance Information

Insurance Subscriber's Name____**Insured SS# or ID#**_____________________________

Subscriber's Date of Birth______________________ **Subscriber's Employer** ____

Dental Insurance Company _____________________________**Group #** _______________**Phone Number** ________________________

Medical Information

Name and phone number of physician ____

My last physical exam was ____

Joint replacement: Have you ever had a joint replacement? If yes, type and year ____

Name of Orthopedist: ______________________________________ Type of antibiotic pre-med you take_____________________

Have you ever have taken Osteoporosis medications? Please list: ____

Please list ALL Medications: **Dosage**: **For treatment of**:

____

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Do you have or have you ever had: **Please circle**

High Blood Pressure Low Blood Pressure AIDS Bleeding Problems GERD/Reflux Hepatitis

Heart Disease Heart Murmur HIV Kidney Trouble Ulcers Respiratory Problems Stroke

Cancer (*type*_________________________) Chemotherapy Radiation Other___________________________________

If you answered yes to any of the above, please explain further: ____

____

Please list all medication allergies: ____

Are you allergic to latex? _______________________________ **FEMALES**: Are you pregnant? ___________________

Do you use tobacco? __________________ If so, what kind?____

Dental Information

When and where were your last dental x-rays taken? ____

Have you ever had a full mouth x-ray? ____________**Have you ever had nitrous oxide sedation** *(laughing gas)?*________________

Is there any specific aspect of dental treatment which makes you particularly anxious? ____________________________________

Have you ever had instruction on the correct methods of brushing and flossing your teeth? _________________________________

Have you ever had Orthodontic (braces) treatment? ____

Do you, or have you ever had pain related to your jaw muscles or joints? ____

Have you ever been told that you have Periodontal (gum) Disease? ____

There are several methods available to make teeth appear whiter, straighter, longer, shorter, etc. Would you like information on one or more of those methods? *(for example, Whitening, Cosmetic Bonding, Porcelain Veneers, Crowns)*

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It is necessary for us to get messages to you concerning upcoming appointments and your dental care in general. Information listed on this sheet is used for this purpose. Please list any restrictions you would like to place on our use of this information:

____

I understand that payment for any and all services rendered are my responsibility. If I have dental insurance, I understand also that any and all fees or portions of fees for services rendered that are not paid for by my dental insurance company are my responsibility.

____ _________________________

Patient Signature Date