Welcome to our office! Joseph A. Rossi DDS and his staff will strive to provide you with the best possible dental care. To help us meet all your healthcare needs, please fill out this form completely. If you have any questions, we will be happy to assist you. Please fill out this form using ink.

Personal Information:

Name: _____ **SS#** _____

Address _____ **City:** _____ **State:** _____ **Zip:** _____

Height: _____ **Weight:** _____ **Birthdate:** _____ **Age:** _____ **Phone#:** _____

Male ____ **Female** ____ **Child**____ **Single** ____ **Married** ____ **Divorced** ____ **Widowed** ____ **Separated**____

Employer/ School: _____ **Phone#** _____ **Ext:** _____

Whom may we thank for referring you? _____

Spouse's Name _____ **Birthdate:** _____ **SS#:** _____

Spouse's Employer _____ **Phone#** _____ **Ext:** _____

Parents names if Patient is a minor: **Father** _____ **Birthdate:** _____

Mother _____ **Birthdate:** _____

Medical Health History: Current Health Status(circle one): Excellent Good Fair Poor

Date of Last Physical: _____ **Name/Phone# of Physician:** _____

Are you taking any medications now? **Yes** **No** **If yes, list medication(s):** _____

_____

Do you currently have or have you ever had any of the following: *(Please circle yes or no)*:

Heart Disease	yes	no	Arthritis	yes	no	Liver Disease	yes	no
Angina Pectoris	yes	no	Hemophilia	yes	no	Diabetes	yes	no
Heart Murmur	yes	no	Anemia	yes	no	Ulcers	yes	no
Congenital Heart Defects	yes	no	HIV Positive or AIDS	yes	no	Epilepsy	yes	no
Scarlet Fever	yes	no	Cancer	yes	no	Fainting or Dizzy spells	yes	no
Rheumatic Fever	yes	no	Lung Disease	yes	no	Glaucoma	yes	no
Artificial Heart Valve	yes	no	Tuberculosis (TB)	yes	no	Venereal Disease or STD	yes	no
Mitral Valve Prolapse	yes	no	Asthma	yes	no	Cold Sores or Herpes	yes	no
Stroke	yes	no	Hay Fever	yes	no	Kidney Disease	yes	no
High Blood Pressure	yes	no	Hepatitis/Jaundice	yes	no	Drug/Alcohol Addiction	yes	no
Artificial Joint	yes	no	Herbal Medicines	yes	no	Smoking or Tobacco	yes	no

Have you ever been told to Premedicate (take antibiotics) before dental appointments? Yes No

Are you allergic to: **Penicillin** _____ **Codeine** _____ **Local Anesthetic** _____ **Sulfa** _____ **Latex**_____

Other Allergies? _____

Women: Are you pregnant at this time? **Yes** **No** **If yes, stage of pregnancy (Months)** _____

Is there anything related to your medical history that you feel we should be aware of? _____

Dental History:

What is the reason for your visit today? _____

Are you bothered by any of the following: **Headaches** **Yes** **No**

Pain in or near your ears? **Yes** **No**

Sore areas in your mouth? **Yes** **No**

Are you having any pain or discomfort at this time? **Yes** **No**

If yes, please describe it: _____

Do you clench or grind your teeth? **Yes** **No**

Have you ever been treated by a Dental Specialist? **Yes** **No**
(Oral Surgeon, Orthodontist, Endodontist,Pedodontist or Periodontist)

Are you familiar with the term "Preventive Dentistry"? **Yes** **No**

Do you frequently have bad breath? Yes No

Do you have tender or swollen gums? Yes No

Do your gums bleed easily when you brush or floss? Yes No

Are you happy with the appearance of your teeth? **Yes** **No**

If not, why? _____

When was your last Dental visit? _____ **What was done?** _____

How often do you brush your teeth? _____ **How often do you floss?** _____

What texture of toothbrush do you use? (circle) **Extra soft** **soft** **medium** **hard**

Is there anything about your Dental History you would like us to be aware of? _____

_____

_____

_____