

Annette Merlino DMD Gentle Family Dentistry



Address City State Zip Home # Cell #/Carrier Work Phone E-mail Emergency Contact Phone Employer Social Security # Occupation Marital Status How were you referred to us? Spouse/Parent's name Contact Phone Insurance Information Primary Insurance Subscriber Name Relationship to patient Subscriber Birth date Social Security # Subscriber employer Insurance Company Group # Policy/ID# Deductible Maximum yearly benefit Does pat. have a secondary ins.? Secondary Insurance Subscriber Birth date Social Security # Insurance Company Insurance Subscriber Name Relationship to patient Subscriber Name Relationship to patient Subscriber Birth date Social Security # Insurance Company Insurance Subscriber Name Relationship to patient Subscriber Birth date Social Security # Insurance Company Insurance Subscriber Birth date Social Security # Insurance Company In	Name		Age	Birth date		Sex
E-mail Emergency Contact Phone	Address		City		_State	Zip
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Subscriber Name	Spouse/Parent's name		_Contact Phon	e		
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Subscriber Birth date			Primary Insura	<u>ance</u>		
Subscriber employerPolicy/ID#	Subscriber Name		Rel	ationship to patient		
Group #Policy/ID#Does pat. have a secondary ins.?	Subscriber Birth date		Social Security	#		
Maximum yearly benefit	Subscriber employer		Ins	urance Company_		
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Signature of patient (or parent/guardian if minor)	X	· · · · · · · · · · · · · · · · · · ·		D	ate	

Health History

Barbiturates	Codeine Erythromycin	lodine Latex Rubber	Local Anesthetic Penicillin	Sulfa Drugs Tetracycline
Are you currently under a	n physicians care? _	If yes, for what?		
Physicians name		Last Visit	Phone #	
		d the correlating diagnosis		
Have you ever had or cu	urrently do have ar	ny of the following? Chec	ck only those that apply	<u>'</u> .
Abnormal Bleeding		Blood Transfusion	Low Blood	l Pressure
Allergies		Diabetes	Mitral Val	
Anemia		Difficulty Breathing	Rheumatio	
Angina Pectoris		Epilepsy	Sinus Tro	
		Headaches		ubie
Arthritis Artificial Joints		Glaucoma	Stroke	imbo
Artificial Value			Swelling L	.IIIIDS
Artificial Valve		Hemophilia	Thyroid P	obiems
Asthma		High Blood Pressure	Tuberculo	SIS
Back Issues		Kidney Disease	Ulcers	
		Were you given a P		
Hepatitis; If yes whi	ich type?			
Sexually Transmitte	ed Disease; If yes բ	olease specify		
Cancer; If yes did y	ou have radiation?	Did you	u have Chemotherapy?	
Cancer; If yes did y Tobacco use; If yes	ou have radiation? what type and ho	Did you w often?	u have Chemotherapy?	
		Did you woften? Did you nat you feel is important	for us to know.	
Sexually Transmitte Cancer; If yes did y Tobacco use; If yes Please list any other me		nat you feel is important	for us to know.	
Please list any other me Are you pregnant of Are you nursing?	edical information the	Women only gnant? If yes what is you	for us to know.	
Please list any other me Are you pregnant of Are you nursing? Are you using birth	r think you are precontrol? If yes plea	Women only gnant? If yes what is you	for us to know	
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Please list any other me Are you pregnant of Are you nursing? Are you using birth	r think you are precontrol? If yes plea birth control medical birth control medical birth control medical birth. Acknowledgm on this sheet indicate tices on the date indicate do not hesitate to control information.	Women only gnant? If yes what is you ase specify cations can effect blood p Dental History ag or any previous issues ment of Receipt of Notice of the that you have been given icated. If you have any que	for us to know ur Due Date? pressure and cause heat Last Dental Visions such as, bleeding gun Privacy Practices the opportunity to review estions regarding the information.	alth risks.) t ns, pain, sores or and request a copy of