



Paul J. Matrullo, D.D.S., PC & Associates

1280 PARK AVENUE
CRANSTON, RI 02910
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Health Information and History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone: _____ Cell Phone: _____

Employer: _____ Address: _____ Business Phone: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Primary Physician: _____ Phone: _____ City & State: _____

Date of last physical examination: _____ Date of last blood test/work up: _____

Other Physicians & Specialists:

Name: _____ Specialty: _____ Phone: _____ City & State: _____

Name: _____ Specialty: _____ Phone: _____ City & State: _____

1. Within the last 3 years, have you been hospitalized or had surgery? Yes No

If Yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY medications ANY special precautions before dental appointments? Yes No

If Yes, please explain: _____

3. Are you taking ANY drugs, medications, or treatments at this time? Yes No

(If you brought a complete list with you, give that to the receptionist instead.)

Prescribed: _____

Over-the-counter (OTC) medications (such as Advil, allergy medication, sleeping aids, etc.):

Vitamins, natural or herbal preparations and/or dietary supplements:

Are you having or have you ever had radiation or chemotherapy treatments? Yes No

If Yes, for how long? _____ Name of facility performing treatment _____

4. Are you taking or have you ever taken / been treated with a Bisphosphonate (Fosamax)? Yes No

5. Are you allergic to or have you ever had any reaction to any of the following drugs?

- | | | | |
|---|--------------------------------------|-------------------------|------------------|
| ___ Penicillin (or related drugs) | ___ Clindamycin (Cleocin) | ___ Keflex (Cephalexin) | ___ Erythromycin |
| ___ Barbiturates/Sleeping pills | ___ Tranquilizers (Valium) | ___ Codeine | ___ Tetracycline |
| ___ Aspirin/Ibuprofen (Advil, Motrin, Nuprin) | ___ NSAID (Celebrex, Vioxx, Anaprox) | ___ Iodine | ___ Sulfa Drugs |

6. Are you allergic to or have you ever experienced an unusual reaction to:

- | | | |
|--------------|----------------------------------|-------------------------------|
| ___ Latex | ___ Metals or jewelry | ___ Dental anesthesia (local) |
| ___ Fluoride | ___ Nitrous Oxide (laughing gas) | ___ General anesthesia |

7. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? Yes No

If Yes, please list: _____

8. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question.)

| | YES | NO | | YES | NO |
|--|-----|-----|--|-----|-----|
| Congenital heart defects | ___ | ___ | Asthma | ___ | ___ |
| Angina or chest pains | ___ | ___ | Hay fever, skin or food allergies, or allergies in general | ___ | ___ |
| Atherosclerosis | ___ | ___ | Sinus problems | ___ | ___ |
| Congestive heart failure | ___ | ___ | Tuberculosis, emphysema, lung disorder | ___ | ___ |
| Coronary artery disease | ___ | ___ | Skin problems | ___ | ___ |
| Heart surgery | ___ | ___ | A sore or wound that bleeds easily or does not heal | ___ | ___ |
| If Yes, type & date _____ | | | A thyroid problem or disease | ___ | ___ |
| Heart attack | ___ | ___ | Arthritis | ___ | ___ |
| If Yes, date _____ | | | Glaucoma or any eye disease | ___ | ___ |
| Rheumatic heart disease/rheumatic fever | ___ | ___ | Epilepsy, feinting, or other seizure disorder | ___ | ___ |
| Infective endocarditis | ___ | ___ | Any kidney problems | ___ | ___ |
| Heart valve damage/mitral valve prolapse | ___ | ___ | Diabetes (Type I or Type II) | ___ | ___ |
| Artificial heart valve | ___ | ___ | Ulcers, acid reflux, or stomach problems | ___ | ___ |
| Pacemaker | ___ | ___ | A compromised immune system (Lupus, HIV, AIDS, radiation immune problem) | ___ | ___ |
| Stroke or CVA | ___ | ___ | A sexually transmitted disease (STD) | ___ | ___ |
| High blood pressure | ___ | ___ | Any mental health issues | ___ | ___ |
| Low Blood pressure | ___ | ___ | Do you have a problem with snoring? | ___ | ___ |
| Anemia | ___ | ___ | If Yes, would you like to be treated for it? | ___ | ___ |
| Hemophilia or bleeding disorder | ___ | ___ | Hepatitis, jaundice, or other liver problems | ___ | ___ |
| Excessive bleeding from a cut or incident | ___ | ___ | An organ transplant | ___ | ___ |
| Artificial joint, joint surgery, or prosthesis | ___ | ___ | Do you smoke? | ___ | ___ |
| If yes, what joint or area: _____ | | | | | |
| When was the operation done: _____ | | | | | |
| Any form of cancer | ___ | ___ | Do you think you might be pregnant? | ___ | ___ |
| WOMEN ONLY: | | | Are you using birth control medication? | ___ | ___ |
| Are you pregnant? | ___ | ___ | Are you taking hormone replacement therapy? | ___ | ___ |
| If Yes, what is your due date: _____ | | | | | |
| Are you presently nursing? | ___ | ___ | | | |

9. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? Yes No

If Yes, please explain: _____

10. Why do you seek dental treatment? _____

11. Do you consider the condition of your oral health: Excellent___ Good___ Fair___ Poor___

12. When was your last dental visit? _____ **What was done?** _____

13. Have you had any problems associated with any previous dental treatment? Yes No

If Yes, please explain: _____

CONSENT – To the best of my knowledge, all of the preceding information is correct, and if there is ever any change in health or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care. I understand that all x-rays taken in this office shall remain the property of Dr. Matrullo. Should I desire a transfer of these records, I will be responsible for a duplicating fee. I understand that all charges are my ultimate responsibility. I further understand that all balances remaining after insurance coverage (if any) has fulfilled its obligation are my responsibility. I understand that if I do not pay any amount which is owed you within 30 days after receipt of your statement of services rendered, then I will be in default of this agreement, and I will pay interest and the reasonable cost which you incur to collect the balance owed you, including reasonable attorney's fees to the extent permitted by law.

Signature _____ Date _____

(Parent or guardian, if patient is a minor)

Reviewed by: _____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

