# Robert Cammarata, D.D.S.

Today's Date:

**PATIENT INFORMATION**

| Last Name: | First Name: | Middle Name: | ❑ Mr ❑ Miss<br>❑ Mrs ❑ Ms |
|---|---|---|---|
| Do You Have A Preferred Name: | Date of Birth: | Age: | Sex:<br>❑ Male ❑ Female |
| Social Security Number: | | Marital Status (circle one)<br>Single / Married /Child / Other | |
| Street Address: | City: | State: | Zip Code: |
| Home Phone Number:<br>( ) | Cell Phone Number:<br>( ) | Email Address: | |
| Occupation: | Employer: | Employer Phone Number:<br>( ) | |

| Who Referred You (please check one) | ❑ Dr. | ❑ Family / Friend | ❑ Insurance Company | ❑ Other: |
|---|---|---|---|---|

**HEALTH HISTORY**

| Name of your Medical Doctor: | Date of Last Visit: | Phone Number:<br>( ) |
|---|---|---|
| Name of Previous Dentist: | | Phone Number:<br>( ) |
| Date of Last Dental Visit: | Reason for Last Dental Visit: | Date of Last X-rays |
| Reason for Seeking Dental Care at This Time: | | |

| How often do you: | Brush ____ times per ______ for approximately ____ minutes | Floss ____ times per ______ |
|---|---|---|

| How do you feel about today dental treatment | ❑ relaxed ❑ a little uneasy ❑ tense ❑ anxious ❑ very anxious |
|---|---|

| Local Pharmacy: | Address: | Phone Number:<br>( ) |
|---|---|---|

| DENTAL HEALTH HISTORY: | | | |
|---|---|---|---|
| Do you have or have you ever had any of the following (please check): | | | |
| Aching teeth | ❑YES ❑NO | Cold sores | ❑YES ❑NO |
| Sensitivity to hot foods or liquids | ❑YES ❑NO | Swollen glands | ❑YES ❑NO |
| Sensitivity to cold foods or liquids | ❑YES ❑NO | Are you clenching | ❑YES ❑NO |
| Sensitivity to sour foods or liquids | ❑YES ❑NO | Are you gringing | ❑YES ❑NO |
| Sensitivity to sweet foods or liquids | ❑YES ❑NO | Jaw pain or tiredness | ❑YES ❑NO |
| Growths, or swelling in your mouth | ❑YES ❑NO | Does your jaw hurt when you chew | ❑YES ❑NO |
| Sensitive gums | ❑YES ❑NO | Areas of food trapped between the teeth | ❑YES ❑NO |
| Bleeding gums | ❑YES ❑NO | Does your jaw ever lock | ❑YES ❑NO |
| Loose teeth | ❑YES ❑NO | Dry mouth | ❑YES ❑NO |
| Broken or missing teeth or fillings | ❑YES ❑NO | Orthodontic treatment | ❑YES ❑NO |
| Does your jaw hurt when you open wide | ❑YES ❑NO | Are you aware of an uncomfortable bite | ❑YES ❑NO |
| Clicking or popping jaw that bothers you | ❑YES ❑NO | Bad breath | ❑YES ❑NO |
| Clicking or popping jaw that bothers other | ❑YES ❑NO | | |
| Are you apprehensive about dental treatment? | ❑YES ❑NO | | |
| Do you want complete dental care? | ❑YES ❑NO | | |
| Have you had problems with previous dental treatment? | ❑YES ❑NO | | |
| Do you gag easily? | ❑YES ❑NO | | |
| Do you wear dentures? | ❑YES ❑NO | | |
| Do you have difficulty chewing your food? | ❑YES ❑NO | | |
| Do you chew on only one side of your mouth? | ❑YES ❑NO | | |
| Do you avoid brushing any part of your mouth because of pain? | ❑YES ❑NO | | |
| Do you take fluoride supplements? | ❑YES ❑NO | | |
| Are you satisfied with the appearance of your teeth? | ❑YES ❑NO | | |
| If you could change your smile, what would you change ________________________________ | | | |

| IN CASE OF EMERGENCY | | |
|---|---|---|
| Name of Local Relative or Friend: | Relationship to Patient: | Phone Number: ( ) |

By my signature below I affirm;
All of the information included on this form is correct and accurate.
I give consent to receive dental treatment and to receive dental anesthetics for the above named patient.
I authorize my dental office to contact me by using any of the above contact information.
I will be responsible to inform this office of any changes in address, phone number, employment, and insurance information by requesting a new information form.
Any outstanding balance such as co-insurance, deductible, denials due to change in coverage, non-participating plans, or no show fees ($125.00) are patient responsibility. Outstanding patient responsibility older than 60 days after date of service will be charged a late fee of 1.5% per month on any outstanding balance. I agree to pay any attorney fees and collection costs in the event of default of payment.

ASSIGNMENT: I hereby assign my insurance benefits to be paid directly to the Dr. Robert Cammarata. I understand that I am financially responsible for all non-covered services if I choose to go forward with treatment.

I acknowledge that I received the Notice of Privacy Practices.

_______________________________ Patient/Guardian Signature

_______________ Date

## INSURANCE INFORMATION

**(Please give your insurance card and photo ID to the receptionist after completion of this form)**

### PRIMARY INSURANCE

| Person Responsible for Bill: | Date of Birth: | Address (if different): | Phone Number: ( ) |
|---|---|---|---|

| Occupation: | Employer: | Employer Phone Number: ( ) |
|---|---|---|

| Please Indicate Primary Dental Insurance: | ❑ Aetna | ❑ Delta | ❑ Guardian | ❑ Other: |
|---|---|---|---|---|

| Subscribers Name: | Subscribers Social Security Number: | Date of Birth: |
|---|---|---|
| Policy Number / Subscriber ID: | Group Number: | Insurance Company Phone Number: ( ) |

| Insurance Company Street Address: | City: | State: | Zip: |
|---|---|---|---|

| Patients Relationship to Subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

### SECONDARY INSURANCE

Name of Secondary Dental Insurance (if applicable):

| Subscribers Name: | Subscribers Social Security Number: | Date of Birth: |
|---|---|---|
| Policy Number / Subscriber ID: | Group Number: | Insurance Company Phone Number: |

| Insurance Company Street Address: | City: | State: | Zip: |
|---|---|---|---|

| Patients Relationship to Subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|