VICTOR L. RICCARDI, D.D.S., P.C.

Welcome to our office. We hope to help you enjoy optimal dental health and make your appointments as pleasant as possible. If at any time you have any questions, please do not hesitate to ask. Please complete the following and remember it will be held in strictest confidence.

PATIENT INFORMATION

Patient Name_____
Last First Middle
Home Address_____
Street/Apt. # City Zip
Male/Female_____Birth Date_____Social Security #_____ Marital Status_____
E-Mail Address_____Cell Phone_____Home Phone_____
Occupation_____Firm Name_____ Bus. Phone_____
If Minor, Parents Name_____
If Married, Spouse's Name _____ Cell Phone_____
Spouse's Occupation_____Firm Name_____Bus. Phone_____
Referred By_____
Who should be notified in case of any emergency?_____Phone_____

PERSONAL MEDICAL HISTORY PLEASE CIRCLE

1. Has there been any change in your health in the last year?…… Yes No
2. Are you in good health?…… Yes No
3. Date of last physical examination_____Dental Exam_____
4. Do you have a health condition a physician is treating?…… Yes No
   If so, what? _____
5. Have you ever had a serious illness or operation?……Date:…… Yes No
   If so, what? _____
6. Who is your physician? _____Phone Number _____
7. Do you have or have you ever had any of the following? **PLEASE CHECK**

___ Anemia	___High Blood Pressure	___Thyroid Problems	___Cranial Stents
___Arthritis, Rheumatism	___Jaundice	___Tuberculosis	___ Dental Implants
___Asthma	___Jaw Pain	___Ulcer	___ Body Implants
___Circulatory Problems	___Kidney Disease	___Allergies or hives	___GERD
___Cortisone Treatments	___Liver Disease	___Artificial Heart Valves	___ Anxiety/Depression
___Cough, persistent or bloody	___Low Blood Pressure	___Artificial Joints or Screws	
___Diabetes	___Respiratory Disease	___ Bleeding Abnormally	
___Emphysema	___Scarlet Fever	___ Blood Disease	
___Epilepsy or seizures	___Shortness of Breath	___Congenital Heart Defect	
___Fainting or dizziness	___Skin Rash	___Heart Murmur	
___Glaucoma	___Weight Loss	___Mitral Valve Prolapse	
___Heart Problems	___Stroke	___Pace Maker	
___Hepatitis Type _____	___Swollen Feet or Ankles	___Rheumatic Fever	
___Herpes	___ Swollen Neck Glands	___Heart Valve Surgery	

8. Drug allergies? If so, what?_____ Yes No
9. Are you taking any drugs or medications? If so, what? _____ Yes No
   _____
10. Have you taken Fen Phen or Redux diet pills, or do you have an eating disorder?…….. Yes No
11. Have you ever taken Fosamax or any other oral or intravenous treatment (bisphosphonates) for bone tumors or osteoporosis?..... Yes No
12. Have you ever had radiation treatment, chemo treatment for tumor, growth or other conditions?..... Yes No
13. Are you allergic to carbocaine, novacaine, xylocaine, latex or metals?…… Yes No
14. Have you tested positive for HIV?…… Yes No
15. Women… are you pregnant or nursing?…….. Yes No

ACCOUNTING INFORMATION

Payment is appreciated at the time of your services. We gladly accept checks, cash, MC, Visa, AMX and Discover cards. We are an out-of-network insurance provider. If we file your insurance, you are responsible for any portion not paid. Please indicate your preference:

____ Check ____ Cash payment at the time of appointment
____ MC/VISA/AMX/Discover

SIGNATURE_____**DATE**_____