Susan Caliri DDS

Patient Information

PATIENT'S LAST NAME / TITLE	FIRST NAME	MIDDLE	SEX	CELL PHONE
CURRENT ADDRESS	CITY	STATE	ZIP	HOME PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	WORK PHONE	
EMPLOYER NAME		FULL ADDRESS OF EMPLOYER		
PRESENT POSITION		IF STUDENT, NAME OF SCHOOL/COLLEGE		
EMAIL ADDRESS	EMERGENCY CONTACT			

PARENTAL / FINANCIAL INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT		RELATIONSHIP		
CURRENT ADDRESS	CITY	STATE	ZIP	HOME PHONE

DENTAL INSURANCE INFORMATION

SUBSCRIBER'S FULL NAME	DATE OF BIRTH			
I.D. #	RELATIONSHIP TO PATIENT			WORK PHONE
INSURANCE COMPANY		GROUP / LOCAL NUMBER		
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP	PHONE
EMPLOYER NAME		FULL ADDRESS OF EMPLOYER		

SECONDARY DENTAL INSURANCE YES ☐ NO ☐

SUBSCRIBER'S FULL NAME	DATE OF BIRTH
I.D. #	RELATIONSHIP TO PATIENT
INSURANCE COMPANY	GROUP / LOCAL NUMBER

WHOM MAY WE THANK FOR REFERRING YOU?

PLEASE COMPLETE REVERSE SIDE →

Confidential Patient Health Questionnaire

NAME DATE OF BIRTH

NAME OF PHYSICIAN CITY DATE OF LAST PHYSICAL

ARE YOU IN GOOD HEALTH? YES ☐ NO ☐

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:
(INCLUDING ASPIRIN, ASPIRIN-LIKE PRODUCTS, ORAL CONTRACEPTIVES):

ARE YOU PREGNANT? YES ☐ NO ☐ IF YES, HOW MANY MONTHS?

DO YOU SMOKE? YES ☐ NO ☐ IF YES, HOW MUCH?

HAVE YOU HAD ANY OF THE FOLLOWING?

YES ☐ NO ☐ HEART MURMUR
YES ☐ NO ☐ HEART PROBLEMS
YES ☐ NO ☐ ARTIFICIAL VALVES
YES ☐ NO ☐ PACEMAKER
YES ☐ NO ☐ HIGH BLOOD PRESSURE
YES ☐ NO ☐ CIRCULATORY PROBLEMS/STROKE
YES ☐ NO ☐ RHEUMATIC FEVER
YES ☐ NO ☐ JOINT REPLACEMENT

YES ☐ NO ☐ DIABETES
YES ☐ NO ☐ RADIATION TREATMENTS
YES ☐ NO ☐ SEIZURE DISORDER
YES ☐ NO ☐ KIDNEY PROBLEMS
YES ☐ NO ☐ HEPATITIS/LIVER PROBLEM
YES ☐ NO ☐ EXCESSIVE BLEEDING
YES ☐ NO ☐ CANCER/TUMORS
YES ☐ NO ☐ CHRONIC SINUS/ALLERGIES

YES ☐ NO ☐ ASTHMA
YES ☐ NO ☐ SEXUALLY TRANSMITTED DISEASE
YES ☐ NO ☐ ORAL HERPES
YES ☐ NO ☐ AIDS OR HIV+
YES ☐ NO ☐ TUBERCULOSIS/LUNG DISEASE
YES ☐ NO ☐ STOMACH OR DUODENAL ULCERS

OTHER HEALTH COMPLICATIONS: _____

IF YES TO ABOVE, PLEASE EXPLAIN: _____

ALLERGIES TO THE FOLLOWING:

PENICILLIN YES ☐ NO ☐ CODEINE YES ☐ NO ☐ LATEX YES ☐ NO ☐ LOCAL ANESTHETICS YES ☐ NO ☐ OTHER (SPECIFY):

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he/she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or the staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

UPDATED HEALTH INFORMATION

INITIALS DATE UPDATED INFORMATION

INITIALS DATE UPDATED INFORMATION

INITIALS DATE UPDATED INFORMATION