LOUIS C. FRANZETTI, D.D.S.
Periodontics — Implant Dentistry

Name First, Middle, Last | Sex | Birth Date | Marital Status

Address (Street, City, State, Zip Code) | Soc. Sec. No.

Home Phone | Cell Phone | Business Name and Address

Dentist's Name | Referred to this office by | Occupation

Person Responsible for Payment of Account | Relation | Phone

Address

Email

Preferred contact method (text, email, phone)

Preferred pharmacy information (name,address,phone)

DENTAL INSURANCE INFORMATION

Primary Insurance Company

Name & Address | Subscriber Soc. Sec. No. OR ID

Subscriber's Name | Date of Birth | Group or Company Name

Group Number | Patient Relationship to Subscriber (self, spouse, child, etc.)

MEDICAL HISTORY

Medical Doctor's Name _____ Address _____ Phone _____

Date of My Last Physical Examination _____ Results: _____

Are you being treated by a medical doctor now? If yes, for what reason? _____

Are you taking any medicine at the present time? If yes, what? _____

Are you sensitive or allergic to any medicine? If yes, what? _____

Have you ever been hospitalized or had any surgical operations? If yes, list reasons and dates _____

Have you ever had any blood transfusions? If yes, give reason _____

Have you had:

☐ Yes	☐No	HIV Positive	☐ Yes	☐No	High Blood Pressure
☐ Yes	☐No	Gall Bladder Disease	☐ Yes	☐No	AIDS
☐ Yes	☐No	Low Blood Pressure	☐ Yes	☐No	Diabetes (Sugar Disease)
☐ Yes	☐No	Asthma	☐ Yes	☐No	Stroke
☐ Yes	☐No	Nervousness	☐ Yes	☐No	Hay Fever
☐ Yes	☐No	Anemia	☐ Yes	☐No	Epilepsy or Seizures
☐ Yes	☐No	Tuberculosis	☐ Yes	☐No	Allergies or Hives
☐ Yes	☐No	Fainting or Dizzy Spells	☐ Yes	☐No	Rheumatic Fever
☐ Yes	☐No	Ulcers (stomach or intestinal)	☐ Yes	☐No	Pacemaker
☐ Yes	☐No	Scarlet Fever	☐ Yes	☐No	Arthritis
☐ Yes	☐No	Thyroid Disease (or Goiter)	☐ Yes	☐No	Heart Murmur
☐ Yes	☐No	Venereal Disease (Syphilis or Gonorrhea)	☐ Yes	☐No	X-Ray or Cobalt Treatment
			☐ Yes	☐No	Heart Disease
☐ Yes	☐No	Psychiatric Treatment	☐ Yes	☐No	Angina Pectoris
☐ Yes	☐No	Kidney Disease	☐ Yes	☐No	Chemotherapy (Cancer, Leukemia)
☐ Yes	☐No	Hepatitis			
☐ Yes	☐No	Bladder Disease	☐ Yes	☐No	Osteoporosis or Osteopenia

☐ Yes ☐No Do you have pain in the chest upon exertion
☐ Yes ☐No Do you have shortness of breath after mild exercise?
☐ Yes ☐No Do you use extra pillows to sleep?
☐ Yes ☐No Do your ankles swell?
☐ Yes ☐No Do you bruise easily?
☐ Yes ☐No Have you ever had Yellow Jaundice?
☐ Yes ☐No Do you have to urinate (pass water) more than 6 times a day?
☐ Yes ☐No Are you thirsty much of the time?
☐ Yes ☐No Dose your mouth frequently become dry?
☐ Yes ☐No Have you lost or gained weight (more than 10 pounds) in the past year?

□ Yes □No Are you following a diet?
□ Yes □No Do you have Cataracts or Glaucoma?
□ Yes □No Do you have difficulty swallowing?
□ Yes □No Has a doctor ever said you have canter or a tumor?
□ Yes □No Have you ever had excessive bleeding from a cut or wound?
□ Yes □No Do you have frequent severe headaches?
□ Yes □No DO you worry a great deal?
□ Yes □No Are you under abnormal stress? (For example marital, business, or social)
□ Yes □No Do you feel you need psychiatric care or advice?
□ Yes □No Do you sometime take medicine to relieve nerviness?
Do you have any disease, condition or problem not listed above?
If yes, explain: _____

Females

□ Yes □No Do you have trouble with your periods? (If you do not menstruate answer no)
□ Yes □No Did you have any complication during pregnancy (if you have never been pregnant answer no)
□ Yes □No Are you pregnant? (Date of delivery _____)
□ Yes □No Are you taking oral contraceptives (Birth control pills?)

Dental History

□ Yes □No Have you had any serious trouble associated with any previous dental treatment? If yes, explain: _____
□ Yes □No Do you bleed excessively, after tooth extraction?
□ Yes □No Have you recently had dental x-rays? If yes, when:_____
□ Yes □No Have you had undesirable reaction to local or general anesthetics (For example, Novocain or Gas)
□ Yes □No Do you clench or grind your teeth?
□ Yes □No Are any of your teeth sensitivity to cold or sweets?
□ Yes □No Are you dissatisfied with the appearance of your teeth?
□ Yes □No Have you had excessive swelling or pain after oral surgery?
□ Yes □No Have your teeth been cleaned recently?
□ Yes □No Do you have bleeding gums?
□ Yes □No Do you have a bad taste in your mouth?
□ Yes □No Does food pack between your teeth?
□ Yes □No Does your jaw click or pop when you chew?
□ Yes □No Have you ever received treatment for periodontal disease?
□ Yes □No Has a dentist ever ground your teeth to correct your bite?
□ Yes □No Are you willing to become actively involved in the treatment of your periodontal disease

Briefly state your feelings toward dentures: _____
_____

What is your chief complaint concerning your mouth or teeth? _____
_____

To the best of my knowledge all of the above answers are true and correct. If I have any change in my health, I will inform Dr. _____ at my next appointment.

_____ _____
Signature of Patient Date

_____ _____
Signature of Doctor Date