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_____ | | | | | |
| Heart attack | ___ | ___ | A thyroid problem or disease | ___ | ___ |
| If Yes, date_____ | | | Arthritis | ___ | ___ |
| Rheumatic heart disease/rheumatic fever | ___ | ___ | Glaucoma or any eye disease | ___ | ___ |
| Infective endocarditis | ___ | ___ | Epilepsy, feinting, or other seizure disorder | ___ | ___ |
| Heart valve damage/mitral valve prolapse | ___ | ___ | Any kidney problems | ___ | ___ |
| Artificial heart valve | ___ | ___ | Diabetes (Type I or Type II) | ___ | ___ |
| Pacemaker | ___ | ___ | Ulcers, acid reflux, or stomach problems | ___ | ___ |
| Stroke or CVA | ___ | ___ | A compromised immune system (Lupus, HIV, AIDS, radiation immune problem) | ___ | ___ |
| High blood pressure | ___ | ___ | | | |
| Low Blood pressure | ___ | ___ | A sexually transmitted disease (STD) | ___ | ___ |
| Anemia | ___ | ___ | Any mental health issues | ___ | ___ |
| Hemophilia or bleeding disorder | ___ | ___ | Do you have a problem with snoring? | ___ | ___ |
| Excessive bleeding from a cut or incident | ___ | ___ | If Yes, would you like to be treated for it? | ___ | ___ |
| Artificial joint, joint surgery, or prosthesis | ___ | ___ | Hepatitis, jaundice, or other liver problems | ___ | ___ |
| If yes, what joint or area:_____ | | | An organ transplant | ___ | ___ |
| When was the operation done:_____ | | | Do you smoke? | ___ | ___ |
| Any form of cancer | ___ | ___ | | | |
| **WOMEN ONLY:** | | | | | |
| Are you pregnant? | ___ | ___ | Do you think you might be pregnant? | ___ | ___ |
| If Yes, what is your due date:_____ | | | Are you using birth control medication? | ___ | ___ |
| Are you presently nursing? | ___ | ___ | Are you taking hormone replacement therapy? | ___ | ___ |

**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)

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**For Office Use Only**

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

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

_____

_____