CARUSO
DENTAL CARE

Thank you for being a new patient at our office.
Please fill out the included form.

You can save your answers & email back to us for a quick review OR you may print off and bring in with you to your appointment.

TO FILL OUT AND EMAIL:
You may open this up and edit on your computer using the Free Adobe Reader. If you do not have this & can't view PDFs or need to update, you can do this by clicking here.

You may also open this using your web browser (Chrome, Firefox, Safari, etc.) and fill in the appropriate fields & save the document.

If you find that your information is not saving correctly, try going through Print - instead of printing to a printer, click save to PDF. You should then be able to save this form with your answers and email it to us.

info@carusodentalcare.com

TYLER R. CARUSO, DMD, PLLC
1 Vanderbilt Park Dr., Ste. 250
Asheville, NC 28803
P (828) 277.5230 • F (828) 277.5614
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New Patient Information and Health History

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PATIENT INFORMATION

PATIENT'S FULL NAME _____ EMAIL_____

MAILING ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ CELL PHONE_____ WORK_____

SOCIAL SECURITY # _____ BIRTHDATE _____ SEX _____

EMPLOYER & ADDRESS _____EMPLOYER PHONE (___) _____

SPOUSE/PARENT'S NAME _____ SPOUSE/PARENT PHONE (___) _____

IF PATIENT IS UNDER THE AGE OF 18, WHO IS RESPONSIBLE FOR THIS ACCOUNT? NAME _____

HOME ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE (_____)_____ STUDENT STATUS: ☐Full Time ☐Part Time

RELATIONSHIP TO PATIENT _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?_____

HOW MAY WE CONTACT YOU FOR APPOINTMENT CONFIRMATIONS? ___CELL PHONE ___TEXT ___EMAIL ___HOME PHONE

INSURANCE INFORMATION

(THE FOLLOWING INFORMATION AND COPIES OF YOUR INSURANCE CARDS ARE REQUIRED IF WE ARE TO FILE INSURANCE FOR YOU)

IS CLAIM RELATED TO AN ACCIDENT? _____ **DATE OF ACCIDENT** _____ **WORKMAN'S COMPENSATION?** _____ **AUTOMOBILE ACCIDENT?** _____

PRIMARY DENTAL INSURANCE:

DENTAL INSURANCE COMPANY _____ GROUP # _____

ADDRESS _____

INSURANCE COMPANY'S PHONE # (_____)_____ DRIVERS LICENSE #_____

POLICY HOLDER'S NAME _____ ADDRESS _____

SOCIAL SECURITY # _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER AND ADDRESS _____

EMPLOYER PHONE (_____)_____

SECONDARY DENTAL INSURANCE:

DENTAL INSURANCE COMPANY _____ GROUP # _____

ADDRESS _____

INSURANCE COMPANY'S PHONE # (_____)_____

POLICY HOLDER'S NAME _____ ADDRESS _____

SOCIAL SECURITY # _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

I authorize release of information relating to my dental claims and payment of the insurance benefits otherwise payable to me to Tyler R. Caruso, DMD, PLLC. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I also understand that a fee of $150.00 will be charged for after hour emergency visits and that fee is in addition to any restorative/ operative procedures performed during the after hour emergency visit.

SIGNATURE OF PATIENT/INSURED _____ DATE _____

TREATMENT AUTHORIZATION AND CONSENT

I hereby authorize the Doctors of Caruso Dental Care and their team to perform comprehensive dental treatment upon me / my child (print patient name) _____.

I understand it is my responsibility to provide Caruso Dental Care with complete and up-to-date medical records. Failing to do so, they will not be able to appropriately diagnose my dental and health needs accurately.
Caruso Dental Care requires radiographs, test and measurements to ethically satisfy their duty of care and enable comprehensive diagnosis. I understand that my providers will have limited diagnostic potential if any or all of the above are not authorized. I will not hold Caruso Dental Care liable upon my refusal of necessary proposed treatment.
I understand there are options such as, local anesthesia, nitrous and various medications to help assist with my dental treatment. I understand that the practice of dentistry is dynamic and my treatment plan may change to meet desired outcomes. I have read and understand the above explanation and I consent for treatment. A full explanation of all complications is available to me upon request from the provider(s) managing my dental case.

Signature_____

Print Name:_____ Date:_____

All patients under the age of 18 require a guardian to accompany them.

_____ **Date**_____
Signature of Parent/Guardian

DENTAL HISTORY

What is your chief concern for your visit today?

_____

_____

Last cleaning: _____Last complete set of x-rays (panoramic& full mouth series):_____Last oral cancer screen:_____

Have you ever been treated for periodontitis (gum disease)? _____Braces_____

What do you like about your smile?

_____

_____

Is there anything you wish you could change about your smile?

_____

_____

Have you experienced any of the following?

☐ Jaw pain? ☐ Loose teeth? ☐ Swollen/bleeding gums? ☐ Bad breath? ☐ Clenching/Grinding? ☐ Headaches?

For the following questions, check the boxes for yes or no. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

	YES	NO
HAS THERE BEEN ANY CHANGE IN YOUR HEALTH IN THE LAST YEAR?	☐	☐
DATE OF LAST PHYSICAL EXAMINATION _____		
ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF SO, EXPLAIN _____		
_____		
NAME AND PHONE NUMBER(S) OF PHYSICIAN(S) _____		
HAVE YOU EVER HAD AN OPERATION OR A SERIOUS ILLNESS? IF SO, EXPLAIN _____		
_____		
HAVE YOU EVER HAD A BAD REACTION TO LOCAL ANESTHESIA?	☐	☐
PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING BIRTH CONTROL PILLS, OVER-THE-COUNTER DRUGS OR HERBALS) _____		
_____		
_____		
ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY DRUGS OR MEDICATIONS (PENICILLIN, CODEINE, OR LATEX) _____	☐	☐
HAVE YOU HAD RADIATION FOR A TUMOR, GROWTH OR OTHER CONDITION?	☐	☐
HAVE YOU EVER TAKEN CORTISONE OR OTHER STEROIDS?	☐	☐
DO YOU SMOKE OR USE TOBACCO? IF SO, HOW MUCH? _____	☐	☐
DO YOU WEAR A REMOVABLE DENTAL APPLIANCE?	☐	☐
ARE YOU PREGNANT? IF SO, HOW MANY WEEKS? _____ Nursing?	☐	☐
DO YOU REQUIRE ANTIBIOTIC PRE-MEDICATION FOR DENTAL TREATMENT? (heart valve problems, artificial joints, etc.	☐	☐
IF SO, WHAT ANTIBIOTIC? _____		
RATE YOUR CURRENT STRESS LEVEL ON A SCALE OF 1 TO 10, WITH 1 BEING VERY LOW STRESS AND 10 VERY HIGH _____.		

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS THAT YOU HAVE HAD OR HAVE EXPERIENCED SYMPTOMS OF:

☐ EPILEPSY OR SEIZURES	☐ HIV (AIDS)	☐ THYROID PROBLEMS
☐ STROKE	☐ VENEREAL DISEASE	☐ CANCER OR LEUKEMIA
☐ CHEST PAIN	☐ HEPATITIS, Type _____	☐ DIABETES, Type _____
☐ CONGENITAL HEART DISEASE	☐ KIDNEY DISEASE	☐ ANEMIA
☐ HEART TROUBLE	☐ SINUS TROUBLE/HAY FEVER	☐ BLEEDING PROBLEMS
☐ HEART MURMUR	☐ ASTHMA	☐ COLITIS
☐ HIGH BLOOD PRESSURE	☐ EMPHYSEMA	☐ ULCERS
☐ MITRAL VALVE PROLAPSE	☐ BRONCHITIS	☐ FAINTING SPELLS
☐ RHEUMATIC FEVER	☐ PERSISTENT COUGH	☐ GLAUCOMA
☐ CARDIAC PACEMAKER	☐ TUBERCULOSIS	☐ ARTHRITIS

Have you taken Phen-Fen or Redux?_____

Are you currently taking any bisphosphonate medication for osteoporosis? (Actonel, Boniva, Fosamax, Risedronate, Didronel)_____

Do you have acid reflux or GERD?_____

Are you taking any blood thinning medications?_____

Have you had a joint replacement in the past 2 years?_____

PLEASE NOTE ANYTHING ADDITIONAL THAT WE SHOULD BE AWARE OF:

_____

_____

_____

_____

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____

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