DR. MICHAEL DAGOSTINO
6887 Ridge Road
Parma, Ohio 44129
440-842-2171

PATIENT INFORMATION

Welcome to our office. It is our sincere hope that your visits here will be comfortable and satisfying. Please take a few minutes to complete this confidential questionnaire so that we may better serve you.

Patients Name ______ Birthdate ______ Gender ❑ *Male* ❑ *Female*

Patients Address ______ City ______ State ______ ZIP ______ Phone ( ) _____ - ______

Patient's Employer ______ Employer's Address ______ E-mail Address ______

Employer's Phone ( ) _____ - ______ Number of Years Employed ______ Social Security Number ______

Marital Status : ❑ *Single* ❑ *Married* ❑ *Separated* ❑ *Divorced* ❑ *Widowed*

Spouse's Name ______ Number of Dependents ______ Spouse's Social Security Number ______

Spouse's Employer ______ How did you learn of our office? ______

Emergency phone number (other than residence) ( ) _____ - ______ Relationship to Patient ______

Who will pay this account (whose name will appear on billing statement) ❑ *Self* ❑ *Spouse* ❑ *Parent or Guardian*

If your spouse, parent or guardian is responsible for your account, please fill in this section.

Responsible Party's Name ______ Birthdate ______ Gender ❑ *Male* ❑ *Female*

Name of Insured ______ Address ______ Phone ( ) _____ - ______

Responsible Party's Employer ______ Number of Years Employed ______ Social Security Number ______

Employer's Address ______ Phone ( ) _____ - ______

Do you have Dental Insurance coverage? ❑ Yes ❑ No (If "Yes" please complete the " Insurance Information" Form)

Family Doctor's Name ______ Address ______ Phone ( ) _____ - ______

Date of last physical exam ______

Do you have a Master Card or Visa? ❑ Yes ❑ No

If you have , or have had, any of the following, please write "YES"

___ Any Heart Problems
___ High Blood Pressure
___ Low Blood Pressure
___ Circulatory Problems
___ Nervous Problems
___ Radiation Treatments
___ Heart Murmur

___ Excessive Bleeding
___ Allergies to Anesthetics
___ Hepatitis (date______)
Is your disease still active ? ______
___ Previous Surgery
___ Joint replacement

___ Malignancies
___ Mumps
___ Psychiatric Care
___ Rheumatic Fever
___ Scarlet Fever
___ Sinus Problems
___ Cardiac Pacemaker

___ Stroke
___ Anemia
___Arthritis
___Asthma
___ Diabetes
___ Epilepsy
___ Tonsillitis

___ Tuberculosis
___ Ulcer
___ Venereal Disease
___ AIDS
I am allergic to the following medication
______
______

Are you pregnant? ______ Blood Pressure S ______ / D ______

Are you having any discomfort at this time? ______

How long since you have been to a dentist? ______

Was your treatment completed? ______

Did you have X-Rays? ______

How often did you visit a dentist before then? ______

Have you lost any teeth? ______

Why? ______

Any complications with extractions? ______

Denture/Partial Wearers:

How old is your appliance ? ______

Is there fluoride in your water ? ______

I am currently taking the following medications

1) ______
2) ______
3) ______
4) ______

How Can We Help You?

______
______
______

Please remember payment is expected when services are performed. If procedures are covered in whole or in part by dental insurance I authorize payment to Dr. Michael Dagostino. Any an all balances will be my responsibility in accordance with the office policy.

Signature:______ Date: ______