

**Paul L. Caputo DDS**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

**Medical History**

- |   |     |    |
|---|-----|----|
| 1. Are you having pain or discomfort at this time?  | Yes | No |
| 2. Do you feel very nervous about having dentistry treatment?   | Yes | No |
| 3. Have you ever had a bad experience in a dental office?   | Yes | No |
| 4. Have you been a patient in the hospital during the past 2 years?   | Yes | No |
| 5. Have you seen a medical doctor during the past 2 years?  | Yes | No |
| 6. Have you taken any medicine or drugs in the past 2 years?  | Yes | No |
| 7. Are you allergic or made sick by penicillin, aspirin, codeine or any drugs or medications?<br>(i.e., itching, rash, swelling of hands or feet or eyes) | Yes | No |
| 8. Have you ever had any excessive bleeding requiring special treatment?  | Yes | No |
| 9. Has your medical doctor ever said you have cancer or a tumor?  | Yes | No |
| 10. Have you had any recent surgeries or anesthesia?  | Yes | No |
| 11. Have you had any complications resulting from a surgery or anesthesia?  | Yes | No |
| 12. Do you smoke?   | Yes | No |
| 13. Women: Are you pregnant now?  | Yes | No |

Physicians Name \_\_\_\_\_ Phone # \_\_\_\_\_

**(PLEASE TURN PAGE)**

\*\*\*\*\*

Medical History Review

---

---

---

---

---

---

**Circle any of the following which you have had or have at the present time:**

- |                        |                         |                          |                          |
|------------------------|-------------------------|--------------------------|--------------------------|
| Heart Failure          | Heart Disease or Attack | Angina Pectoris          | High blood pressure      |
| Heart Murmur           | Rheumatic Fever         | Congenital Heart Lesions | Scarlet fever            |
| Artificial heart valve | Bruise easily           | Heart Pacemaker          | Heart surgery            |
| Artificial Joint       | Anemia                  | Stroke Kidney Trouble    | Pain in Jaw Joints       |
| Emphysema Cough        | Tuberculosis (TB)       | Asthma                   | Hay Fever                |
| Sinus Trouble          | Allergies or hives      | Diabetes                 | Thyroid Disease          |
| Ulcers                 | Chemotherapy            | Arthritis                | Rheumatism               |
| Cortisone Medicine     | Glaucoma                | Sickle Cell Disease      | Liver Disease            |
| AIDS                   | Hepatitis A, B, C       | Drug Addiction           | Yellow Jaundice          |
| Blood Transfusion      | Hemophilia              | Venereal Disease         | Syphilis, Gonorrhea      |
| Cold Sores             | Genital Herpes          | Epilepsy or Seizures     | Fainting or Dizzy Spells |
| Nervousness            | Psychiatric Treatment   |                          |                          |

Do you have any disease, condition or problem not listed? Yes      No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever had a change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

I understand I remain personally responsible for the total amount due Dr. Paul Caputo for his services, regardless of the existence of any private dental insurance policy. Dr. Paul Caputo may at any time, demand payments from me immediately upon rendering service, or at any time thereafter at his option.

I understand that Dr. Paul Caputo will attach a 1 1/2% monthly interest charge on any balance which remains unpaid after thirty (30) days. I understand Dr. Paul Caputo may, at his option, pursue this matter into litigation and that the prevailing party will be entitled to an award of attorney's fees and court costs associated with such collection fees.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient, Parent, Guardian