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Welcome to our practice! In maintaining our philosophy of excellence in dentistry it is important that you provide us with an accurate dental and medical history. Thank you for your cooperation.

NAME: _____ BIRTH DATE: ____/____/____
ADDRESS: _____ APT: _____
CITY: _____ ZIP CODE: _____ TELEPHONE: _____
CELL PHONE: _____ E-MAIL ADDRESS: _____
MARITAL STATUS: _____ SOCIAL SECURITY #: _____
DRIVER'S LICENSE: _____

OCCUPATION: _____
EMPLOYER: _____ BUSINESS TELEPHONE: _____
EMPLOYER'S ADDRESS: _____
SPOUSE'S EMPLOYER: _____ BUSINESS TELEPHONE: _____
EMPLOYER'S ADDRESS: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY CONTACT NAME: _____ # _____
EMERGENCY CONTACT NAME: _____ # _____

ACCOUNT TO BE PAID BY: CHECK CHARGE CARD CASH CARECREDIT CHASE HEALTH CARD
DO YOU HAVE DENTAL INSURANCE? YES NO

HEALTH HISTORY

ARE YOU UNDER THE CARE OF A MEDICAL DOCTOR AT PRESENT? YES NO

PHYSICIAN'S NAME _____
ADDRESS _____ PHONE _____

ARE YOU TAKING ANY MEDICATIONS, DRUGS, PILLS? LIST INDIVIDUALLY NAME AND USE. IF EXTENSIVE LIST PLEASE USE ATTACHED FORM.

NAME _____	USE _____
NAME _____	USE _____
NAME _____	USE _____
NAME _____	USE _____
NAME _____	USE _____

MEDICATIONS UPDATE:

DATE _____	NAME _____	USE _____
DATE _____	NAME _____	USE _____
DATE _____	NAME _____	USE _____
DATE _____	NAME _____	USE _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

PENICILLIN ASPIRIN CODEINE ERYTHROMYCIN LATEX

ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATION OR SUBSTANCE (IE LATEX)?

WOMEN: ARE YOU PREGNANT? IF YES, HOW MANY MONTHS? _____

