DR. KEVIN RUSSELO
& ASSOCIATES

Patient Information

Patient Name: _____ Date: _____
Last, First, (Preferred Name)

Gender*: _____

Email address: _____ Date of Birth: _____

Phone (CELL): _____ (Home):_____ (Work): _____ Ext:____

Address: _____
Street Apartment #

_____
City Province Postal Code

**While our clinic recognizes a number of sexes/genders, many insurance companies and legal entities do not. Please understand that the legal name and gender listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.*

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply.

☐HIV/AIDS
☐Allergies _____
_____
☐Penicillin
☐Codeine
☐Seasonal
☐Anemia
☐Arthritis
☐Artificial Joints
☐Asthma
☐Blood Disease
☐Cancer
☐Diabetes
☐Dizziness
☐Epilepsy
☐Excessive Bleeding
☐Fainting
☐Glaucoma
☐Growths
☐Head Injuries
☐Heart Disease
☐Heart Murmur
☐Hepatitis B / C
☐H. Blood Pressure
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Mental Disorders
☐Nervous Disorders
☐Pacemaker
☐Pregnancy
Due: _____
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatic Fever
☐Rheumatism
☐STI
☐Sinus Problems
☐Stomach Problems
☐Stroke
☐Tuberculosis
☐Tumors
☐Ulcers
☐OTHER:
_____
_____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

- Have you ever had any complications following dental treatment?
  ☐Yes ☐No *If yes, please explain:* _____
- Have you been admitted to a hospital or needed emergency care during the past two years?
  ☐Yes ☐No *If yes, please explain:* _____
- Are you now under the care of a physician?
  ☐Yes ☐No *If yes, please explain:* _____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification?
  ☐Yes ☐No *If yes, please explain:* _____

- Are you presently taking any kind of medication?..... ☐Yes ☐No

Specify: A. _____ Reason: _____
B. _____ Reason: _____
C. _____ Reason: _____
D. _____ Reason: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. _____
Patient Signature

DR. KEVIN RUSSELO & ASSOCIATES

Dental History

- How frequently do you see your dentist? .....☐6 Months ☐Yearly ☐Other: _____
- Have you had oral hygiene instruction in.....☐Brushing ☐Flossing ☐Other: _____
- Have you ever had local anaesthetic?..... ☐Yes ☐No Any complications: _____
- Are any of your teeth sensitive to.....☐Cold ☐Sweets ☐Heat ☐Other: _____
- Do your gums bleed when.....☐Brushing ☐Flossing ☐Spontaneously
- Do your gums feel swollen or tender? ..... ☐Yes ☐No
- Do you catch food between your teeth? ..... ☐Yes ☐No
- Are you aware of any loose teeth? ..... ☐Yes ☐No
- Have you ever had a full mouth series of x-ray? ..... ☐Yes ☐No
- Does your jaw crack, pop or grate when you open widely? ..... ☐Yes ☐No
- Do you grind or clench your teeth?..... ☐Yes ☐No

Smile Analysis

- Yellow, stained or discolored teeth ..... ☐Yes ☐No
- Gaps, or space between teeth ..... ☐Yes ☐No
- Missing teeth ..... ☐Yes ☐No
- Teeth worn down, chipped or uneven ..... ☐Yes ☐No
- Teeth appear too small, short, large or long ..... ☐Yes ☐No
- Prior dental work that appears unnatural ..... ☐Yes ☐No
- Crowns, bridges that appears unnatural ..... ☐Yes ☐No
- Gray, black or silver (mercury) fillings in your teeth ..... ☐Yes ☐No
- "Gummy" smile (too much gums show when smiling) ..... ☐Yes ☐No
- Are you self-conscious about your teeth or smile? ..... ☐Yes ☐No

Referral Information

Whom may we thank for referring you to our practice?

☐Dental Office ☐Yellow Pages ☐Newspaper ☐School ☐Work ☐Other:_____

☐Friend (patient) ☐Relative (patient) .....Name:_____

PATIENT ACKNOWLEDGEMENT AND CONSENT

I, the undersigned, certify that all above medical and dental information is true and I have not omitted any pertinent information.

I hereby consent to the performing of all dental and surgical treatments deemed necessary or advisable, including the use of local anesthetic.

I acknowledge that I will assume full responsibility for the payment of all fees associated with these procedures. I acknowledge that my insurance plan may not cover all services provided, but that I will be responsible for the full payment of all fees. If my account has an outstanding balance, I authorize Dr. Kevin Russelo and Associates to charge such balance to my credit card account on file.

I authorize the release, to my insuring company plan administrator, of the information contained in any claims submitted electronically.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian