Family & Cosmetic Dentistry
308 Dorla Court, Suite 202, Zephyr Cove, NV 89448
(775) 588-8484

Thank you for visiting. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ Height _____ Weight _____

Phone: Home _____ Social Security # _____

Work _____ Please Circle:

Cell _____ **Sex:** Female/Male **Status:** Married/Single/Divorced/Widow

Emergency: Name _____ Phone _____

By making an appointment we consider that your confirmation to the appointment made.
As a courtesy we can confirm by email or text.

Please circle if you would like to confirm by: EMAIL/TEXT or BOTH
Email Address: _____

Who may we thank for referring you to us? _____

Dental Insurance:

Dental Insurance: Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

The personal information and medical history requested below is to enable Dr. John Bocchi DDS in an aid to evaluating your dental health thoroughly and completely. It is important for you to give complete answers so that I may give you the personal attention that you deserve. This will become part of your dental record and will be held in the strictest confidence. Thank you!

Personal Information

Date: _____

Patients Name: _____ Date of Birth: _____

Health History

Please circle YES or NO to any of the following:

Abnormal Bleeding	YES	NO	Joint Replacement	YES	NO	Please circle if you have **"EVER"** taken any of the following Bishosphonates:		
Alcohol Abuse	YES	NO	Joint Replacement Date: _____					
Allergies	YES	NO	Kidney Problems	YES	NO			
Anemia	YES	NO	Liver Disease	YES	NO	Actonel	YES	NO
Angina Pectoris	YES	NO	Low Blood Pressure	YES	NO	Bonefos	YES	NO
Arthritis	YES	NO	Mitral Valve Prolapse	YES	NO	Boniva	YES	NO
Artificial Heart Valve	YES	NO	Pace Maker	YES	NO	Didronel	YES	NO
Asthma	YES	NO	Psychiatric Problems	YES	NO	Skelid	YES	NO
Blood Transfusion	YES	NO	Radiation Therapy	YES	NO	Zometa	YES	NO
Cancer	YES	NO	Seizures	YES	NO			
Chemotherapy	YES	NO	Shingles	YES	NO	Do you smoke?	YES	NO
Colitis	YES	NO	Sickle Cell Disease	YES	NO	Do you take birth control?	YES	NO
Congenital Heart Defect	YES	NO	Sinus Problems	YES	NO	Are you pregnant?	YES	NO
Diabetes	YES	NO	Stroke	YES	NO	Are you nursing?	YES	NO
Difficulty Breathing	YES	NO	Thyroid Problems	YES	NO			
Drug Abuse	YES	NO	Tuberculosis	YES	NO			
Emphysema	YES	NO	Ulcers	YES	NO			
Epilepsy	YES	NO						
Facial Blisters	YES	NO	ALLERGIES: Do you have any of the following?					
Glaucoma	YES	NO	Aspirin	YES	NO			
HIV	YES	NO	Codeine	YES	NO			
Aids	YES	NO	Dental Anesthetics	YES	NO			
Heart Attack	YES	NO	Erythromycin	YES	NO			
Heart Murmurs	YES	NO	Latex	YES	NO			
Heart Surgery	YES	NO	Metals	YES	NO			
Hemophilia	YES	NO	Penicillin	YES	NO			
Hepatitis A	YES	NO	Sulfa	YES	NO			
Hepatitis B	YES	NO	Tetracycline	YES	NO			
Hepatitis C	YES	NO	Other: _____					
High Blood Pressure	YES	NO	_____					

Please list any other medications you are currently taking: _____
_____

PLEASE SIGN BELOW

_____
Signature Date