LEARDI FAMILY DENTISTRY

Willowdale Town Center • 690 Unionville Road • Kennett Square, PA 19348
Robert K. Leardi, D.M.D., P.C. (610) 444-8744

Date: _____

PATIENT: (Mr., Mrs., Ms., Dr.) First Name _____ M.I. _____ Last Name _____

Sex: ☐ Male ☐ Female Date of Birth _____ Age _____ Social Security # _____

Street _____ City _____ State _____ Zip _____

Home Tel. # _____ Business Tel. # _____ Cell Tel. # _____

Email Address _____

Pharmacy Tel. # _____ Physician _____ Referred by _____

INSURANCE INFORMATION

Patient: Student ☐ Full Time ☐ Part Time School Name/Address _____

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single

PATIENT: Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other

Name _____ Social Security # _____ Home Tel. # _____

Street _____ City _____ State _____ Zip _____

Employer: _____ Tel. # _____

NO MINORS UNDER AGE 18 WILL BE TREATED WITHOUT DIRECT CONSENT AND/OR SIGNATURE ON MEDICAL HISTORY.

EMERGENCY CONTACT

Name _____ Relation to Patient _____

Home Tel. # _____ Business Tel. # _____ Cell Tel. # _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

Signature of Patient: (Parent or Guardian if a minor) **X**

Date: **X**

FEES & PAYMENTS

We make every effort to keep down the cost of your dental care. You can help by paying upon completion of each visit. An estimate of the charge for any procedure you may require will be given to you upon request. If you have any dental insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.**

I hereby acknowledge that I am responsible for payment of services rendered by Dr. Robert Leardi and /or staff and I agree to pay for such services.

I hereby authorize payment directly to Robert K. Leardi, DMD, PIC of the dental benefits for services rendered. I authorize Robert K. Leardi, DMD, PIC to release to my insurance company any information acquired in the course of my examination or treatment.

X (Patient or Parent if minor) (Date)

A COPY OF THIS DOCUMENT MAY BE CONSIDERED AS VALID AS THE ORIGINAL

HEALTH HISTORY

To our patients: The scope of general dentistry includes the diagnosis and adjunctive treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. Health problems may affect the outcome of treatment. Thank you for answering the following questions.

Reason for Today's Visit:

	Yes	No
Have there been any changes in your general health in the past year?	☐	☐
Are you under the care of a physician? Date of last visit to Primary Care M.D.:	☐	☐
If so, for what are you being treated?	☐	☐
Have you had any illness, operation or been hospitalized in the past five years?	☐	☐
If so, please describe		
Have you had any surgery in the last five years?	☐	☐
If so, when: Type of surgery:	☐	☐
Do you have a prosthetic joint or artificial heart valve?	☐	☐
If so, when: Name of Surgeon:	☐	☐

HEALTH HISTORY

Have you had or do you currently have	Yes	No	Notes	Have you had or do you currently have	Yes	No	Notes
Stroke	☐	☐		Cancer	☐	☐	
HIV	☐	☐		Chemotherapy	☐	☐	
Diabetes/high blood sugar	☐	☐		Do you have any reason to be immunosuppressed?	☐	☐	
High blood pressure	☐	☐		Bone strengthening drugs	☐	☐	
Chest pain, angina	☐	☐		A history of drug abuse	☐	☐	
Are you on dialysis?	☐	☐		A history of alcohol abuse	☐	☐	
Heart attack(s), When	☐	☐	Date_____	Do you smoke?	☐	☐	
Stomach ulcers/acid reflux	☐	☐		Bleeding problems	☐	☐	
Cardiac pacemaker/ Implanted defibrillator	☐	☐		Blood disorder/anemia	☐	☐	
Heart surgery/Stents placed	☐	☐		Pain & clicking in jaws while eating	☐	☐	
Bronchitis, chronic cough	☐	☐		Eating disorder	☐	☐	
Radiation treatment for cancer	☐	☐		Epilepsy	☐	☐	
Asthma	☐	☐		Mental health problems	☐	☐	

MEDICATION

ARE YOU NOW TAKING	Yes	No	Notes	ARE YOU NOW TAKING	Yes	No	Notes
Any kind of medicine or drugs (please list) _____	☐	☐		Herbal supplements (please list) _____	☐	☐	
				Anticoagulants	☐	☐	
				Steroids/bone strengthening drugs	☐	☐	

ALLERGIES

Any allergies or reactions to	Yes	No	Notes	Any allergies or reactions to	Yes	No	Notes
Local anesthetics	☐	☐		Aspirin/Ibuprofen	☐	☐	
Penicillin/Amoxicillin	☐	☐		Codeine/other narcotics	☐	☐	
Other medications (please list)_____				Other than drug allergies (please list)_____			

WOMEN

	Yes	No	Notes		Yes	No	Notes
Are you pregnant?	☐	☐		Are you nursing?	☐	☐	
Estimated delivery date: _____				Are you taking birth control pills?	☐	☐	

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding alternate methods.

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his staff, responsible for any errors or omissions that I have in the completion of this form.

X Signature Of Patient:	Date:	X Signature Of Patient:	Date:
X Signature Of Patient:	Date:	X Signature Of Patient:	Date:
X Signature Of Patient:	Date:	X Signature Of Patient:	Date:
X Signature Of Patient:	Date:	X Signature Of Patient:	Date:
X Signature Of Patient:	Date:	X Signature Of Patient:	Date: