Jess J Santucci, DDS

TMJ Sleep Aesthetic

Guest _____ Birth Date _____ Married ___ Single ___
Last First M.I.

Social Security #_____

Home Address _____
Street City State Zip Code

Telephone (Home) _____ (Work) _____ (Cell) _____

Email _____ Preferred Method of Contact _____

If minor, Parent's or Legal Guardian's name _____

Person to contact in case of emergency _____ Telephone # _____

Whom may we thank for referring you to our practice? _____

Are you happy with your smile? Yes ___ No ___

Is there anything we can do to make your experience with us exceptional ? _____

_____

Dental Insurance

Name of Insurance Company _____ Group/Policy # _____

Subscriber Name _____ Social Security # _____ Birth Date _____

Name of (Secondary) Insurance Company _____ Group/Policy # _____

Subscriber Name _____ Social Security # _____ Birth Date _____

_____

I understand that I am responsible for all costs of dental treatment. I hereby authorize **Jess J Santucci, DDS** to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge. I grant the right to **Jess J. Santucci, DDS** to release my dental/health histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____ _____
Guest Signature Date

Health History

Are you under a physician's care now? Yes __ No __ Physician Name _____ Telephone _____

Have you had any surgeries in the last 5 years? Yes __ No __ If Yes, what? _____

Are you taking any medications? Yes __ No __ If Yes, what? _____

Do you have any allergies or adverse reactions to any medications, anesthetic or latex? Yes __ No __

If Yes, what? _____

Please ***CIRCLE*** yes or no on the following:

Heart Problem	Y N	Pacemaker	Y N	Diabetes	Y N	Cancer	Y N
Heart Murmur	Y N	Rheumatic Fever	Y N	Abnormal Bleeding	Y N	HIV Antibodies	Y N
Mitral Value Prolapse	Y N	Tuberculosis	Y N	Asthma	Y N	AIDS	Y N
Heart Valve	Y N	Lung Disease	Y N	High Blood Pressure	Y N	Psychological Care	Y N
Artificial Joints	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Hepatitis A,B or C	Y N
Ulcers	Y N	Thyroid	Y N	Kidney Trouble	Y N	Liver Disease	Y N
Glaucoma	Y N	Hemophilia	Y N	Sickle Cell Disease	Y N	Bruise Easily	Y N
Neurological Disorder	Y N	Stroke	Y N	Anemic	Y N	Pain in Jaw Joints	Y N

Fen-Phen/Redux Yes __ No __ **Women only**: Pregnant/trying to get pregnant? Yes __ No __

Have you ever had any other serious illness not circled above? Yes __ No __ Explain _____

Lifestyle

	Yes	No
Significant weight change in the last year	___	___
Vitamins, herbs or mineral supplements _____	___	___
Fatigue easily	___	___
Sleep well	___	___
Snore	___	___
Trouble breathing when asleep	___	___
Do you sleep with more than two pillows	___	___
More than two alcoholic drinks per day	___	___
Smoke or use tobacco	___	___

Reviewed by Dr. _____ Date _____

JESS J. SANTUCCI, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____