Family & Cosmetic Dentistry
5465 Kietzke Lane Reno, NV 89511
(775) 786-1911

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 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 l 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
Alcohol Abuse	YES	NO
Allergies	YES	NO
Anemia	YES	NO
Angina Pectoris	YES	NO
Arthritis	YES	NO
Artificial Heart Valve	YES	NO
Asthma	YES	NO
Blood Transfusion	YES	NO
Cancer	YES	NO
Chemotherapy	YES	NO
Colitis	YES	NO
Congenital Heart Defect -	YES	NO
Diabetes	YES	NO
Difficulty Breathing	YES	NO
Drug Abuse	YES	NO
Emphysema	YES	NO
Epilepsy	YES	NO
Facial Blisters	YES	NO
Glaucoma	YES	NO
HIV	YES	NO
Aids	YES	NO
Heart Attack	YES	NO
Heart Murmurs	YES	NO
Heart Surgery	YES	NO
Hemophilia	YES	NO
Hepatitis A	YES	NO
Hepatitis B	YES	NO
Hepatitis C	YES	NO
High Blood Pressure	YES	NO

Joint Replacement	YES	NO
Joint Replacement Date: ____________		
Kidney Problems	YES	NO
Liver Disease	YES	NO
Low Blood Pressure	YES	NO
Mitral Valve Prolapse	YES	NO
Pace Maker	YES	NO
Psychiatric Problems	YES	NO
Radiation Therapy	YES	NO
Seizures	YES	NO
Shingles	YES	NO
Sickle Cell Disease	YES	NO
Sinus Problems	YES	NO
Stroke	YES	NO
Thyroid Problems	YES	NO
Tuberculosis	YES	NO
Ulcers	YES	NO

ALLERGIES: Do you have any of the following?

Aspirin	YES	NO
Codeine	YES	NO
Dental Anesthetics	YES	NO
Erythromycin	YES	NO
Latex	YES	NO
Metals	YES	NO
Penicillin	YES	NO
Sulfa	YES	NO
Tetracycline	YES	NO

Other: ______________________________

____

Please circle if you have **"EVER"** taken any of the following Bishosphonates:

Actonel	YES	NO
Bonefos	YES	NO
Boniva	YES	NO
Didronel	YES	NO
Skelid	YES	NO
Zometa	YES	NO

Do you smoke?	YES	NO
Do you take birth control?	YES	NO
Are you pregnant?	YES	NO
Are you nursing?	YES	NO

Please list any other medications you are currently taking: ____

____

PLEASE SIGN BELOW

____

Signature Date