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Welcome

We are pleased to welcome you to the office of Adam D. Fusco, DMD. Dr. Fusco is a fully licensed Dentist in the state of Tennessee. In order to best care for you, please take a few minutes to fill out this form as completely as possible. If you have any questions while filling it out, we will be glad to answer them for you.

Patient Information

Name ____ Soc. Sec. #____________________
Last Name First Name Initial
Preferred Name or Nickname (if any) ____________________
Home Address ____
City ____________________ State _________ Zip _________
Home Phone __________________ Cell Phone __________________ Email
____
□ Male □ Female Age _________ Birthdate _________
□ Single □ Married

Employed By __________________ Occupation _____________ Business Phone ______________

How did you hear about our office? ____
Who may we thank for referring you to our office? ____
We greatly appreciate referrals to our office from friends, family, and co-workers!
Notify in case of emergency _________________________________ Home Phone ______________
Cell Phone _____________ Business Phone _______________

Dental History

What would you like for us to do today? ____
Are you in dental pain/discomfort? □ Yes □ No
Who was your former Dentist? __________________ City _________ State _________
Date of last dental care or examination? __________________

Please put a check (√) next to the box if you have had / currently have any of the following:
□ Loose teeth or broken fillings □ Sensitivity when Biting □ Sensitivity to Cold
□ Sensitivity to Hot □ Sensitivity to Sweets □ Grinding or clenching teeth
□ Clicking or popping Jaw

How often do you brush? _____________ How often do you floss? ______________

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? □ Y □ N
If yes, please explain ____

Medical History

Primary Medical Doctor's Name____ Phone ______________________
Date of last visit to Medical Doctor____________________ Preferred Pharmacy: ___________________________
Have you ever been told that you need to take antibiotics prior to dental treatment? □ Y □ N
Do you have any prosthetic/artificial joints (ie. hip replacement, knee replacement)? □ Y □ N
If so, which joint was replaced & when? ________________Have you ever taken Fen-Phen/Redux? □ Y □ N
Have you ever taken or are you currently taking a bisphosphonate medication (examples include: Aredia, Zometa, Actonel, Boniva, Didronel, Fosamax, Skelid, Reclast, Aclasta, Atelvia)? □ Y □ N
Have you travelled outside of the country within the last six months? □ Y □ N
Women: Are you pregnant? □ Y □ N If yes, Due Date: _____________ Nursing? □ Y □ N
Taking birth control pills? □ Y □ N

Check Y for yes or N for No if you have had or currently have any of the following:

- □ Y □ N AIDS/HIV Positive
- □ Y □ N Alcohol/Drug Abuse
- □ Y □ N Anaphylaxis
- □ Y □ N Anemia
- □ Y □ N Arthritis, Rheumatism
- □ Y □ N Artificial Heart Valves
- □ Y □ N Asthma

Frequency of inhaler use? _______

- □ Y □ N Allergy Prone
- □ Y □ N Autoimmune Disease
- □ Y □ N Back Problems
- □ Y □ N Blood Disease
- □ Y □ N Blood Thinner
- □ Y □ N Cancer
- □ Y □ N Chemical Dependency
- □ Y □ N Cholesterol Problems
- □ Y □ N Chemotherapy
- □ Y □ N Circulatory Problems
- □ Y □ N Cortisone Treatments
- □ Y □ N Cough, persistent
- □ Y □ N Cough up blood
- □ Y □ N Diabetes
- □ Y □ N Epilepsy
- □ Y □ N Fainting
- □ Y □ N Food Allergies
- □ Y □ N Glaucoma
- □ Y □ N Headaches
- □ Y □ N Heart Murmur
- □ Y □ N Heart Problems

Describe ______________________

- □ Y □ N Hemophilia / Abnormal Bleeding
- □ Y □ N Hereditary Problems
- □ Y □ N Herpes, Oral
- □ Y □ N Herpes, Genital
- □ Y □ N Hepatitis
- □ Y □ N High Blood Pressure
- □ Y □ N Kidney Disease or Malfunction
- □ Y □ N Liver Disease
- □ Y □ N Material Allergies (**Latex**, Wool, Metal, Chemicals)
- □ Y □ N Mitral Valve Prolapse
- □ Y □ N Nervous Problems
- □ Y □ N Pacemaker/Heart Surgery
- □ Y □ N Psychiatric Care
- □ Y □ N Rapid weight gain or loss
- □ Y □ N Radiation Treatment
- □ Y □ N Respiratory Disease
- □ Y □ N Rheumatic/Scarlet Fever
- □ Y □ N Seizures
- □ Y □ N Shingles
- □ Y □ N Shortness of breath
- □ Y □ N Skin rash
- □ Y □ N Stroke
- □ Y □ N Swelling of feet or ankles
- □ Y □ N Thyroid disease or malfunction
- □ Y □ N Tobacco Habit
- □ Y □ N Tonsillitis
- □ Y □ N Tuberculosis
- □ Y □ N Ulcer/Colitis
- □ Y □ N Venereal Disease

Please list any medications or supplements you are currently taking, if any: ________________________________
____
____

Please list any medications that you are allergic to, if any: ____
____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change if my medical status, I will inform the doctor.

Signature ____ Date ________________________