**WELCOME!** 

## Foxhallsmiles.com Joseph A. Catanzano III, DDS

NAME				M_	FN	Aarital S	Status
Last	First		. Int. Suff	ix			
(If Child): Parent/Guardian Name					Din	th Doto	
How do you wish to be addresse Eligible for Medicare?						_	
		License Numb	ei allu Stai	ıe			
Address	Dusinss						
Employer		s Address					
Occupation		Handid was 1	h u - lh t	cc	: 2		
Phone:   Home ()		Other Femily	Mambara i	our om n this D	Proctice?		
□Cell ()							
□Work ()		In Event of Emergency, whom may we notify? What is their contact information?					
□Emerg ()							
□Email			(Please a	lso check	k the box for	your prefe	erred method of contact)
I agree that payment for all services rende paid, I agree to pay a monthly service chaincluding attorney's fees and court costs s Release: I authorize Dr. Joseph A. Catanza authorize the release of any information of administering claims for insurance benefit another health care professional or to the 6the information on this page.	ge of 1.5% on hould collection ano III to perform oncerning my ( s. I authorize re	any balance due aft on be necessary. orm diagnostic proce or my child's) healtl elease of any inform	er 60 days and edures and tree th care, advice nation concern	d in addi atment as and trea ning my	s may be nec atment provid (or my child)	esponsible essary for led for the s) health o	e for all collection costs  proper dental treatment.  purpose of evaluating an care, advice and treatmen
					ъ		
Signature(patient signature (or parent or guardian)					υ	ate	
	DENTAL H						
Do you have a specific dental cond							
What are your long term goals for	your oral he	alth?					
What are your expectations of our When was your last regular visit?_	office?				1 1		
When was your last regular visit?	dia (air	How ofter	n are your i	coutine	dental exa	ms?	
Do you think you have active gum Do your gums ever bleed or are the							
Do you have any loose teeth?							
Do you floss regularly? He							
Do you brush regularly? Ye	our routine a	and how long do	vou brush:	•			
What type of toothbrush (i.e. hand use?	electric and	brand as well as	s type i.e. s	oft/med	dium/hard)	and too	thpaste do you
How do you feel about your smile							
Is there anything you would like to							
Have you ever considered brighter	ing your sm	nile?					
Have you ever whitened your teeth	ı? If	so, how and wit	h what prod	ducts?_			
Have you ever had orthodontics?_	When_						
Have you ever had any jaw pain or							
Do you, or has anyone ever told yo							
If so, do you wear an appliance to							
Do you or has anyone ever told yo							
Have your past dental experiences							
If not, would you like to explain?_				Logt	dota of via		_(Optional)
Name of your previous dentist? Reason for changing to our office?							
Date of last xrays?							
Tobacco and Alcohol Use Histor		L-1ays					<del></del>
Tobacco Use: Do you smoke?		ı use smokeless	tobacco sn	uff. or	chew?		
How much do you smoke or use?_	— Joyot	w long have you	smoked or	used it	t?		-
Have you ever tried to quit?\	Would you b	e interested in a	uitting now	or in t	he future?		_
Alcohol Use: Do you drink?							
Have you ever noticed any sores o							

Rheumatic Fever* Artificial Heart Valve*  Cardiac Pacemaker* Pulmonary shunt High Blood Pressure Low Blood Pressure Bacterial endocardidits*  Asthma Emphysema Ciducy Problems Renal Dialysis* Thyroid Disease Arthritis/Gout Rheumatism  Fainting or dizziness Glaucoma Tumors or Growths Psychiatric Care Arthritis/Gout Rheumatism Hives/Rash Nervousness	N ' ' I NT	an whom you see regularly	y? If so please p	provide the following information
Are you on a special diet?  Do you have any allergies to any medications or substances? (Please circle and/or list)  Penicillin Latex Metal Aspirin Codeine Acrylic  Or women: are you - Pregnant/trying to get pregnant (Please das check the box if applicable)  Or you have or have you ever had any of the following? (Please circle all that apply to yourself)  Heart Disease/Surgery* Heart Attack-Falure Congenital Heart Disorder Redeath Hemophilia (bleeding problem)  Leukenia Angina (Chest Pain Ratificial Heart Disease)  Remeintal Flater Ploapse (with regurgitation)  Scarlef Fever Remeintal Frever*  Remeintal Flater Ploapse (with regurgitation)  Low Blood Fressure  Bacterial endocurdidits*  Remeintal Flater Ploapse (with regurgitation)  Stomach Intestinal Disease  Tuberculosis Tuberculosis Cardiac Pacemaker*  Platent Disease Plating of Limbs  Low Blood Fressure  Bacterial endocurdidits*  Remain Dialysis*  Tuberculosis Cardia Plater Ploapse (with regurgitation)  Stomach Intestinal Disease  Remain Dialysis*  Tuberculosis Cardia Plater Ploapse (with regurgitation)  Stomach Intestinal Disease  Nervousness  Remain Dialysis*  Tuberculosis Cardiac Plater Plating of dizease Plating of Limbs  Low Blood Fressure  Bacterial endocurdidits*  Tuberculosis Cardiac Plater Plating of Cardiac Plater Plating of dizease Plating of Limbs  Low Blood Fressure  Bacterial endocurdidits*  Tuberculosis Cardiac Plater Plating of Cardiac Plater Plating of Remover Plating of Cardiac Plater Plating of Remover Plating Pla	Physician's Name		Phone	Fax
Date of your last bloodwork tests?	Address		City	
Are you on a special diet?  Do you have any allergies to any medications or substances? (Please circle and/or list)  Perior women: are you - Pregnant/trying to get pregnant   Nursing   Taking oral contraceptives (Please Acrylic Please Plear Heart Mack/Tailure Angina/Chest Pain Heart Atack/Tailure Congenital Heart Disorder Mitral Valve Prolapse (With regurgiation)   Scarler Fever Artificial Heart Valve*   Congenital Heart Sever   Stinus Trouble   Stinus Trouble   Stinus Prosite   Heart Mack/Tailure   Congenital Heart Sever   Stinus Trouble   Stinus Prosite   Heart Mack/Tailure   Congenital Heart Sever   Stinus Trouble   Stinus Prosite   Heart Mack/Tailure   Congenital Heart Disorder   Stinus Prosite   Heart Mack/Tailure   Congenital Heart Sever   Stinus Trouble   Stinus Prosite   Heart Mack/Tailure   Congenital Heart Sever   Stinus Trouble   Stinus Prosite   Heart Mack/Tailure   Congenital Heart Sever   Stinus Trouble   Stinus Prosite   Heart Mack/Tailure   Congenital Heart Sever   Stinus Trouble   Stinus Prosite   Hepatitis A (Infectious)   Swelling of Limbs   Liver Disease   Hepatitis A (Infectious)   Swelling of Limbs   Liver Disease   Hepatitis A (Infectious)   Swork   Hepatitis A (Infectious)   Hepatitis A (Infectious)   Swork   Hepatitis A (Infectious)   Swork   Hepatitis A (Infectious)   He				
Have you ever had a serious injury to your head or neck?Please discuss  Are you taking any medications, pills, drugs, vitamins, or nutritional supplements? Please list:  Medication				
Are you on a special diet?  Do you have any allergies to any medications or substances? (Please circle and/or list)  Pencicillin Latex Metal Aspirin Codeine Acrylic  Or women: are you - Pregnant/trying to get pregnant   Nursing   Taking oral contraceptives (Please also check the box    applicable)  Or you have or have you ever had any of the following? (Please circle all that apply to yourself)  Heart DiseaseSurgery*   Heart DiseaseSurgery*   Heart DiseaseSurgery*   Heart AttackFailure   Congenital Heart Disease   Hemophilia (bleeding problem)   Leukemia   Recent Weight Loss   Diabets (If so, what does your blood sugar run? pulmonary shunt   High Blood Pressure   Low Blood Pressure   Condended Pressure   Low Blood				
Are you taking any medications, pills, drugs, vitamins, or nutritional supplements? Please list:  Medication Dosage Reason Medication Dosage Reason Do you have any allergies to any medications or substances? (Please circle and/or list)  Penicillin Latex Metal Aspirin Codeine Acrylic  Or women: are you - Pregnant/trying to get pregnant Nursing Taking oral contraceptives (Please also check the box if applicable)  Or you have or have you ever had any of the following? (Please circle all that apply to yourself)  Heart DiseaseSurgery* Anemia Sickle Cell disease Irregular Heart Beat Angina/Chest Pain Hemophilia (bleeding problem)  Leukemia Congenital Heart Disorder Mitral Valve Prolapse (with regurgitation) Swelling of Limbs Lung Disease (with regurgitation) Swelling of Limbs Lung Disease Hepatitis 8 or Condest Asthma Liver Disease Hepatitis 8 or Condest Problems Rendication Artificial Heart Valve* Cardiac Pacemaker* Palmonary shunt High Blood Pressure Bacterial endocardidits* Tuberculosis Cancer* List type Bacterial endocardidits* Stomach Intestinal Disease Reference Disease Hepatitis Son Chemotherapy Stomach Intestinal Disease Stomach Intest	Have you ever been ho	ospitalized or had a major	operation?Pleas	e discuss
Medication   Dosage   Reason   Dosage	Have you ever had a se	erious injury to your head	or neck?Please	discuss
Are you on a special diet?  Do you have any allergies to any medications or substances? (Please circle and/or list)  Penicillin Latex Metal Aspirin Codeine Acrylic  Other  Corwomen: are you -    Pregnant/trying to get pregnant    Nursing    Taking oral contraceptives  (Please also check the box if applicable)  Oo you have or have you ever had any of the following? (Please circle all that apply to yourself)  Heart Disease/Surgery* Heart Murmur*  Heart AttackFailure Congenital Heart Beat Angina/Chest Pain Heart AttackFailure Congenital Heart Disorder Mitral Valve Prolapse (with regurgitation) Scarlet Fever Mitral Valve Prolapse (with regurgitation) Scarlet Fever Asthma Simus Trouble Asthma Artificial Heart Valve* Cardiac Pacemaker* Pulmonary shunt High Blood Pressure Bacterial endocardidits*  Dispensation  Nervousness  Or the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status, or if nedications change, I shall inform the dentist and the staff at the next appointment without fail.	Are you taking any me	edications, pills, drugs, vit	amins, or nutritional sup	oplements? Please list:
Are you on a special diet?  Or you have any allergies to any medications or substances? (Please circle and/or list)  Penicillin Latex Metal Aspirin Codeine Acrylic  Other  For women: are you -   Pregnant/trying to get pregnant   Nursing   Taking oral contraceptives  (Please also check the box if applicable)  Or you have or have you ever had any of the following? (Please circle all that apply to yourself)  Heart Disease/Surgery*   Bruise Easily/Blood disease   Angina/Ches Pain   Heart Attack/Failure   Leukemia   Leukemia   Leukemia   Leukemia   Leukemia   Heart Attack/Failure   Congenital Heart Disorder Mitral Valve Prolapse (with regurgitation)   Swelling of Limbs   Liver Disease   Hepatitis & Oir Mitral Valve Prolapse (with regurgitation)   Sinus Trouble   Hepatitis & Oir Sinus Trouble			Medication Dosage	e Reason
Are you on a special diet?  Do you have any allergies to any medications or substances? (Please circle and/or list)  Penicillin Latex Metal Aspirin Codeine Acrylic  Other  Or women: are you - Pregnant/trying to get pregnant Nursing Taking oral contraceptives (Please also check the box if applicable)  Or you have or have you ever had any of the following? (Please circle all that apply to yourself)  Heart Disease/Surgery* Heart Murmur* Heart Murmur* Heart Hear Beat Angina/Chest Pain Hemophilia (bleeding problem) Heart Attack/Failure Congenital Heart Disorder Mitral Valve Prolapse (with regurgitation) Scarlet Fever Sinus Trouble Hepatitis B or C Recent Weight Loss Disease Hepatitis A (Infectious) Scarlet Fever Sinus Trouble Hepatitis B or C Repulmonary shunt High Blood Pressure Low Blood Pressure Bacterial endocardidits*  Or Repulmonary shunt Hat I do not and have never had any of the above conditions Pate Menatics and have never had any of the above conditions Pate Menatics or if nedications change, I shall inform the dentist and the staff at the next appointment without fail.				
Do you have any allergies to any medications or substances? (Please circle and/or list)  Penicillin Latex Metal Aspirin Codeine Acrylic  Other  For women: are you -   Pregnant/trying to get pregnant   Nursing   Taking oral contraceptives (Please also check the box if applicable)  Do you have or have you ever had any of the following? (Please circle all that apply to yourself)  Heart Disease/Surgery*   Bruise Easily/Blood disease   Heart Murmur*   Anemia   Sickle Cell disease   Hemophilia (bleeding problem)   Leukemia   Excessive Thirst   Hypoglyciemia   Liver Disease   Mitral Valve Prolapse (with regurgitation)   Swelling of Limbs   Liver Disease   Hepatitis B or C   Sinus Trouble   Hepatitis B or C   Sinus Trouble   Hepatitis B or C   Sinus Trouble   Hepatitis B or C   Stroke   Thyroid Disease   Arthritis/Gout   Arthritis/Gout				
Conting   Cont	Are you on a special di	iet?		_
Or women: are you -   Pregnant/trying to get pregnant   Nursing   Taking oral contraceptives   (Please also check the box if applicable)    Or you have or have you ever had any of the following? (Please circle all that apply to yourself)    Heart Disease/Surgery*   Bruise Easily/Blood disease   Anemia   Sickle Cell disease   Anemia   Anemia   Anemia   Artificial Joints*    Irregular Heart Beat   Anemia   Sickle Cell disease   Anemia   Anemia   Anemia   Anemia   Anemia   Anemia   Anemia   Artificial Joints*    Congenital Heart Disorder   Mitral Valve Prolapse   (with regurgitation)   Scarlet Fever   Sinus Trouble   Asthma   Night sweats   Artificial Heart Valve*   Cold Sores/Fever Blisters   Alcohol or Drug Addiction   Stroke   Convulsions/Epilepsy/Seizure   Artificial Heart Valve*   Emphysema   Kidney Problems   Cancer* List type   Chemotherapy   Stomach Intestinal Disease   Arthritis/Gout   A	Do you have any allerg	gies to any medications or	substances? (Please cir	cle and/or list)
For women: are you - Pregnant/trying to get pregnant  Nursing  Taking oral contraceptives  (Please also check the box if applicable)  Do you have or have you ever had any of the following? (Please circle all that apply to yourself) Heart Disease/Surgery*	Penicillin Latex	Metal Aspi	irin Codeine A	Acrylic
Please also check the box if applicable	Other			
affirm that I do not and have never had any of the above conditions Date  Have you had any other serious illness not checked above? Yes or No. If yes, please discuss:  To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status, or if nedications change, I shall inform the dentist and the staff at the next appointment without fail.  Date	Heart Disease/Surgery* Heart Murmur* Irregular Heart Beat Angina/Chest Pain Heart Attack/Failure Congenital Heart Disorder Mitral Valve Prolapse (with regurgitation) Scarlet Fever Rheumatic Fever* Artificial Heart Valve* Cardiac Pacemaker* Pulmonary shunt High Blood Pressure Low Blood Pressure	Bruise Easily/Blood disease Anemia Sickle Cell disease Hemophilia (bleeding problem) Leukemia Recent Blood Transfusion Swelling of Limbs Lung Disease Sinus Trouble Asthma Emphysema Tuberculosis Cancer* List type X-ray Treatments (Radiation) Chemotherapy	Ulcers Recent Weight Loss Diabetes (If so, what does your blood sugar run?) Excessive Thirst Hypoglyciemia Liver Disease Hepatitis A (Infectious) Hepatitis B or C Night sweats Kidney Problems Renal Dialysis* Thyroid Disease Arthritis/Gout	Cortisone Medication Artificial Joints* Venereal Disease AIDS or HIV Positive Herpes Cold Sores/Fever Blisters Alcohol or Drug Addiction Stroke Convulsions/Epilepsy/Seizures Fainting or dizziness Glaucoma Tumors or Growths Psychiatric Care Alzheimers Disease Hives/Rash
Have you had any other serious illness not checked above? Yes or No. If yes, please discuss:  To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status, or if medications change, I shall inform the dentist and the staff at the next appointment without fail.  Date	L OR			
To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status, or if nedications change, I shall inform the dentist and the staff at the next appointment without fail.  Date	affirm that I do not as	nd have never had any of t	the above conditions	Date
nedications change, I shall inform the dentist and the staff at the next appointment without fail.  Date		or carious illness not abacl	xed above? Yes or No. I	f yes, please discuss:
ignatureDate	Have you had any othe	a serious illiess not check		
	o the best of my knowled	ge, all the preceding answers ar	•	•

PATIENT NAME:\_\_\_\_