FUSCO FAMILY DENTISTRY
"Exceptional Dental Care for the Entire Family"
Adam D. Fusco, DMD

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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
Have you ever had Botox / dermal fillers before? □ Y □ N 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 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 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 _____