



**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

If so, which joint was replaced? \_\_\_\_\_ 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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive       | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes            | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse      | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy            | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous Problems           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis             | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting            | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart Surgery    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Food Allergies      | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Care           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism   | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma            | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches           | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                  | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur        | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Disease        |
| Frequency of inhaler use? _____   | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems      | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergy Prone           | Describe _____  | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease      | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia /        | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back Problems           | Abnormal Bleeding   | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Hereditary Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Thinner           | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes, Oral        | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                  | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes, Genital     | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical Dependency     | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis           | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cholesterol Problems    | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | malfunction  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy            | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease or   | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco Habit              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory Problems    | Malfunction   | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone Treatments    | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease       | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent       | <input type="checkbox"/> Y <input type="checkbox"/> N Material Allergies  | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood          | (Latex, Wool, Metal, Chemicals)   | <input type="checkbox"/> Y <input type="checkbox"/> 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 in my medical status, I will inform the doctor.

Signature \_\_\_\_\_ Date \_\_\_\_\_