DRS. STEFANO GRACIS & MATTEO CAPELLI
ASSOCIATED DENTAL PRACTICE

Via Brera 28/A 20121 Milano, Italy

LAST NAME _____ HUSBAND'S LAST NAME _____

FIRST NAME _____ MARITAL STATUS _____

DATE OF BIRTH / / PLACE OF BIRTH _____ COUNTRY _____

HOME ADDRESS _____

CITY _____ PROV. _____ CAP _____

TAX CODE _____

PROFESSION _____ HOME TELEPHONE _____

INSURANCE COMPANY FOR DENTAL COVERAGE _____ OFFICE TELEPHONE _____

WHO REFERRED YOU TO OUR OFFICE? _____ CELL PHONE _____

MAIN REASON FOR THE CONSULTATION _____ E-MAIL ADDRESS _____

MEDICAL HISTORY

YES	NO	
☐	☐	Have you had any hospitalization or relevant medical conditions in the last 5 years? If yes, explain _____
		Have you suffered or do you suffer from any of the following conditions:
☐	☐	- allergies (if yes, which ones?) _____
☐	☐	- heart disorders (if yes, which ones?) _____
☐	☐	- blood pressure (❑ high ❑ low)
☐	☐	- circulatory or blood disorders (if yes, which ones) _____
☐	☐	- HIV positive
☐	☐	- bronchial asthma
☐	☐	- gastric disorders (if yes, which ones?) _____
☐	☐	- liver disease (if yes, which ones?) _____
☐	☐	- diabetes ❑ type I ❑ type II
☐	☐	- renal (kidney) disease
☐	☐	- neurological disorders (if yes, which ones?) _____
☐	☐	- prostate dysfunction
☐	☐	- thyroid disorders: ❑ hyperthyroidism ❑ hypothyroidism
☐	☐	- eye disorders (glaucoma)
☐	☐	- bone disease (osteoporosis)
☐	☐	Have you undergone any radiotherapy (for cancer treatment)?
☐	☐	Do you have a pacemaker?
☐	☐	Do you wear contact lenses?
☐	☐	Are you taking any medications? If yes, which ones? _____
☐	☐	Are you on any medications for osteoporosis (bisphosphonates)?
☐	☐	Have you had any side-effects from anesthetics, antibiotics or other medications? _____
☐	☐	Are you pregnant? If yes, from how many weeks? _____
☐	☐	Are you a smoker? If yes, how many per day? _____

PLEASE SEE REAR PAGE

DENTAL HISTORY

How often do you see a dentist on the average?

- ☐ every 6 months or less
- ☐ once a year or more
- ☐ only when I need to

How many times do you brush your teeth every day?

- ☐ three or more
- ☐ twice
- ☐ once

YES	NO	
		PERSONAL HISTORY
☐	☐	Are you fearful of dental treatment? On a scale from 1 (least) to 10 (most)? ☐
☐	☐	Have you ever had unfavorable dental experiences or complications from past dental treatments?
☐	☐	Have you ever had trouble in getting numb or had any reactions to local anesthetics?
☐	☐	Did you ever have braces, orthodontic treatment or had your bite adjusted?
☐	☐	Have you had any teeth removed?
		SMILE CHARACTERISTICS
☐	☐	Is there anything about the appearance of your teeth that you would like to change? _____
☐	☐	Have you ever whitened (bleached) your teeth?
☐	☐	Have you ever felt uncomfortable or self conscious about your teeth?
☐	☐	Have you been disappointed with the appearance of previous dental work?
		BITE AND JAW JOINT
☐	☐	Do you/did you have any problems in chewing gum?
☐	☐	Do you/did you have any problems in chewing bagels, baguettes, protein bars or other hard foods?
☐	☐	Have your teeth changed in the last 5 years, become shorter, thinner or worn?
☐	☐	Are your teeth crowded or are they developing spaces?
☐	☐	Do you have more than one bite and squeeze to make your teeth fit together?
☐	☐	Do you bite your nails, chew ice, use your teeth to hold objects or have any other oral habits?
☐	☐	Do you have any problems with sleep or do you wake up with an awareness of your teeth?
☐	☐	Do you brux, clench or squeeze your teeth together during the night or the day?
☐	☐	Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?
☐	☐	Do you suffer from headaches, neck pain, do you clench your teeth during the day or are they sore?
☐	☐	Do you wear or have you ever worn a bite appliance?
		TOOTH STRUCTURE
☐	☐	Have you had any cavities in the last three years?
☐	☐	Does the amount of saliva in your mouth seem too little or do you have difficulty in swallowing any food?
☐	☐	Are any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth?
☐	☐	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?
☐	☐	Do you get food stuck between your teeth?
		GUMS AND BONE
☐	☐	Do your gums bleed when brushing or flossing?
☐	☐	Have you ever experienced gum recession?
☐	☐	Have your teeth become loose on their own (without an injury) or do you have difficulty in eating an apple?
☐	☐	Have you ever noticed an unpleasant taste or odor in your mouth?
☐	☐	Do you experience a burning sensation in your mouth?
☐	☐	Have you ever been treated for gum (periodontal) disease or told that you have lost bone around your teeth?
☐	☐	Is there anyone with a history of periodontal disease in your family?

THE PATIENT MUST INFORM PROMPTLY THE DENTIST IF THERE ARE CHANGES IN THE STATE OF HEALTH OR IN THE MEDICATIONS PRESCRIBED BY HIS/HER TREATING PHYSICIAN

DATE _____ PATIENT'S SIGNATURE _____

Consent to the processing of personal data
According to Law 196/03

I, the undersigned ..... patient in the dental office mentioned above, informed about the rights and limitations under Law 196/03 concerning "the protection of persons and other subjects regarding the processing of personal data" and with the knowledge that, under this law, these data fall into the category of "sensitive", namely the data "revealing racial or ethnic origin, philosophical beliefs, religious or other beliefs, political opinions, membership of political parties, trade unions, religious associations, political organizations as well as personal data disclosing health and sex life", agree and authorize the Associated Dental Practice of Dr. Stefano Gracis and Dr. Matteo Capelli, the doctors responsible for the treatment, and those collaborators specially appointed by them, to handle my personal data solely for diagnostic, therapeutic and scientific purposes.

DATE _____ SIGNATURE _____