Welcome new patients!

Dental Registration & History

General Information

Date_____

Name_____ _____ _____
(Last) (First) (Middle) (Preferred Name)

Home Address_____ _____ _____ _____
(Street) (City) (State) (Zip)

Home Phone (____)_____ **Mobile(____)**_____ **Work (____)**_____

Date of Birth _____/_____/_____ **E-mail Address**_____

Place of Employment_____

Work Address_____ _____ _____ _____
(Street) (City) (State) (Zip)

Spouse's Name (if applicable) _____

Parent's Name (if applicable) _____

Person to call in case of emergency_____ **Phone (___)**_____

Whom may we thank for referring you to our office? _____

Person Ultimately Responsible for Account

Name_____ _____ **Relation to patient** _____
(Last) (First)

Billing Address_____ _____ _____ _____
(Street) (City) (State) (Zip)

Home Phone (____)_____ **Mobile(____)**_____ **Work (____)**_____

Primary Dental Insurance

Name of Insurance_____

Insured's Name_____

Insured's Employer_____

Insured's SS#_____

Group/Policy#_____

Relation _____**Date of Birth**___/___/___

Orthodontic Benefits? Yes _____ **No**_____

Secondary Dental Insurance

Name of Insurance_____

Insured's Name_____

Insured's Employer_____

Insured's SS#_____

Group/Policy#_____

Relation _____**Date of Birth** ___/___/___

Orthodontic Benefits? Yes_____ **No**_____

As a courtesy to our patients we will file your dental insurance for you.

I _____ hereby authorize assignment of my insurance benefits directly to Dr. DiSanto-Rose
(initials)
for services rendered. I understand that I am solely responsible for any balance not paid by my insurance company.
Our policy requires payment in full at the time of the visit, unless other arrangements have been made with the financial coordinator. If an account is not paid within 60 days of the date of service and no financial arrangements have been made, you will be responsible for late and legal fees, collection agency fees, and other expenses incurred in collecting your account.
I authorize Dr. DiSanto-Rose and his staff to perform any necessary procedures needed during diagnosis and treatment, and to release any information required to process insurance claims.

Signature _____Relation_____ Date _____
(If patient is a minor, a parent or guardian must sign)

Dental Health

Please describe your dental problem_____

Name of previous dentist_____

Address of previous dentist_____
(street) (city) (state) (zip)

When was your last dental visit? _____ Are you nervous about dental treatment? _____

How often do you brush your teeth? ____times/day. Type of brush: soft ____med. ___hard ___

How often do you floss your teeth? _____ Do you gag easily? Yes ____ No _____

Do you wear dentures? ____ Upper____ Lower____ When were they made? _____

Do you chew on only one side of your mouth? ____ Right____ Left____

Does your water contain fluoride? Yes____ No____

Please check any of the following you have had:

___Sensitive Teeth	**___Orthodontic Treatment**	**___Sinus Problems**
___Loose Teeth	**___Periodontal Treatment**	**___Mouth Breathing**
___Grinding/Clenching	**___Bleeding Gums**	**___Dry Mouth**
___Popping/Clicking Jaw	**___Unpleasant Taste/Breath**	**___Thumb/Finger Sucking**
___Jaw Pain/Tenderness	**___Food Wedged in Teeth**	**___Nail/Cheek/Lip Biting**
___Head/Neck/Back Aches	**___Lump in Mouth/Neck**	**___Fluoride Supplements**

Other:_____

Medical Health

General Health (Check One): Good _____ Fair _____ Poor _____

Name of Primary Physician _____ _Phone (___)_____

Address of Physician_____
(street) (city) (state) (zip)

Year of your last visit to your physician? _____ Why? _____

Do you have an internal cardiac defibrillator or pacemaker? Yes ____ No ____ Year Placed: _____

Name of Cardiologist_____ Phone (___)_____

Address of Cardiologist_____
(street) (city) (state) (zip)

Year of your last visit to your cardiologist? _____ Why? _____

Have you ever been hospitalized? Yes_____ No_____ If yes, please list when and why:

_____

Please list any medications and dosage you are taking: _____

_____

Are you allergic to? Aspirin _____ Codeine _____ Latex _____Novocaine _____ Penicillin_____

Sulfa _____ Tetracycline_____ Other (describe) _____

Do you require pre-medication before dental visits? Yes___ No___ If yes, why and what is the

name and dosage of the medication you take? _____

Do you have any hip, knee, or artificial joint replacements? Yes _____ No _____

If yes, what type? _____, and when replaced? _____

Name of Surgeon _____ Phone (___)_____

Address of Surgeon_____
(street) (city) (state) (zip)

Have you had any heart surgery? _____ What type?_____ Date_____

Have you ever had excessive bleeding following an extraction? _____

Do cuts take long to heal? _____ Do you have excessive thirst or urination? _____

Are you subject to fainting spells? _____Any marked changes in your weight? _____

Do you have tired spells, weakness, or persistent fever? _____

Have you ever tested positive for the human immunodeficiency virus (HIV)? _____

Have you ever had or been tested positive for hepatitis B or C? _____

Are you pregnant? _____ How many months? _____ Nursing? _____

Are you taking birth control pills? _____

Have you ever had radiation or chemotherapy for cancer or tumors? _____ When? _____

Do you use tobacco in any form? _____ If yes; type, how much, how long? _____

Do you use alcohol beverages (2 or more drinks per day)? _____

Please check any of the following which you have had:

___Heart Problem	**___High Blood Pressure**	**___Jaundice/Liver Disease**
___Heart Murmur	**___Low Blood Pressure**	**___Kidney/Thyroid Problem**
___Rheumatic Fever	**___Arthritis**	**___Cancer/Tumor**
___Mitral Valve Prolapse	**___Asthma/Emphysema**	**___Ulcers**
___Artificial Valve	**___Tuberculosis**	**___Stroke**
___Circulation Problem	**___Artificial Joints**	**___Hepatitis B or C**
___Anemia	**___Diabetes**	**___HIV**
___Hearing Loss	**___Back Problems**	**___Venereal Disease**
___Behavioral Problems	**___Epilepsy/Seizures**	**___Snoring/Sleep Issues**

Please list any conditions I should be aware of_____

I understand the above questions, and to the best of my knowledge have answered them correctly.

Signature_____ Relation _____Date_____
(If patient is a minor, a parent or guardian must sign)

I have reviewed the above dental/medical form with the patient/parent/guardian.

_____ _____
Dr. /Staff **Date**

We appreciate you taking the time to complete these forms as they help us to provide a more comprehensive and safer treatment plan for you.

Thank You Very Much!