Patient Registration

PETITTO
FAMILY DENTAL

Patient Information

Name____ Date _____________________
Date of Birth___________ Age _________ Email Address ______________________________
Home Phone_____________ Cell Phone_____________ Work Phone ________________
Social Security # ____________________ Driver's License # __________________________
Address ____
City_________________________ State __________________________ Zip _________________
Marital Status: _____________ Name of Spouse _____________________________________
Occupation ______________________________ Employer ______________________________
Employer Address ____
Emergency Contact ___________________ Relationship _____________ Phone ___________
How did you hear about us?
___ Insurance Provider List ___ Phone Book ___ Google
___ www.PetittoFamilyDental.com ___ Sign in Front of Office ___ Flyer
___ Another Doctor ___ Other: __________________________________
___ Family / Friend / Whom can we thank for referring you? ______________________
Reason For Visit ____

Insurance

Primary Dental Insurance

Subscriber _________________________
Relationship to patient _____________
Date of Birth _________ SS# ________
Employer __________________________
Work Phone ________________________
Insurance Company ________________
Ins. Phone #________________________
Group # ____________________________

Secondary Dental Insurance

Subscriber __________________________
Relationship to patient _____________
Date of Birth ________ SS# __________
Employer ___________________________
Work Phone _________________________
Insurance Company _________________
Ins. Phone # _________________________
Group # ______________________________

Medical History

Physician ________________ Office Phone____________ Date of Last Exam_________

Question				
Are you under medical treatment now? If so, What?	❑	Yes	❑	No
Have you been hospitalized in the last 2 years? If so, What?	❑	Yes	❑	No
Are you currently taking any medications? If so, Which ones?	❑	Yes	❑	No
Have you lost or gained more than 10 pounds in the last year?	❑	Yes	❑	No
Do you use more than 2 pillows to sleep?	❑	Yes	❑	No
Do you ever wake up from sleep short of breath?	❑	Yes	❑	No
Have you ever had excessive bleeding requiring special treatment?	❑	Yes	❑	No
Do you use tobacco?	❑	Yes	❑	No

Medical History

Bisphosphonates

Question				
Have you ever taken Bisphosphonate medications such as Alendronate (Fosamax), or Boniva for osteoporosis or Padget's Disease?	❑	Yes	❑	No
Were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma for metastatic cancer?	❑	Yes	❑	No

Medical History

Allergies

Are you allergic to or have you had any reactions to the following?

Local anesthetics	❑Yes	❑No	Aspirin	❑Yes	❑No
Penicillin or any other antibiotics	❑Yes	❑No	Metals	❑Yes	❑No
Latex (rubber)	❑Yes	❑No	Iodine	❑Yes	❑No
Sulpha	❑Yes	❑No	Other_____________________________		

Women

Are you pregnant or think you could be pregnant?	❑Yes _____ Months	❑No
Nursing	❑Yes	❑No
Do you use birth control prescriptions?	❑Yes	❑No

Do you have or have had any of the following?

❑ Heart Valve Prolapse	❑ High Blood Pressure	❑ Rheumatism
❑ Heart Failure	❑ Anemia	❑ Arthritis
❑ Heart Attack	❑ Asthma	❑ Pain in Joints
❑ Angina Pectoris (chest pain)	❑ Emphysema	❑ Radiation therapy
❑ Heart Disease	❑ Shortness of Breath	❑ Cancer or Tumor
❑ Congenital Heart Lesions	❑ Hay Fever	❑ Chemotherapy
❑ Scarlet Fever	❑ Allergies or Hives	❑ Thyroid Disease
❑ Artificial Heart Valve	❑ Fainting or Dizzy Spells	❑ Glaucoma
❑ Heart Pacemaker	❑ Epilepsy or Seizures	❑ AIDS or HIV
❑ Heart Surgery	❑ Nervousness	❑ Liver Disease
❑ Any Form of Eating Disorder	❑ Psychiatric Treatment	❑ Cold Sores or Fe
❑ Kidney Trouble	❑ Genital Herpes	❑ Ulcers
❑ Diabetes	❑ Heart Murmur	❑ Hepatitis
❑ Cold Sores or Fever Blisters	❑ Bruise Easily	❑ Drug Addiction
❑ Stroke	❑ Blood Transfusion	❑ Alcoholism
❑ Sickle Cell Disease	❑ Hemophilia	❑ Tuberculosis
❑ Recreational Drug Use	❑ Swollen Ankles	❑ Leukemia
❑ Rheumatic Fever	❑ Heart Murmur	❑ Joint Replacement

Do you have any disease, conditions, or problem not listed above? If so, please list: ____

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Dental History

Date of last dental visit__________________ Date of last dental cleaning____________________

Date of dental x rays____________________ Previous dentist's name______________________

How often do you brush your teeth?_______________ How often do you floss? _____________

Are you extremely fearful of the dentist? ❑ Yes ❑ No

Are you happy with the appearance of your smile? ❑ Yes ❑ No

Is there anything about your smile that you would like to change? ❑ Yes ❑ No

If yes, Please Explain:

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Please mark "yes" or "no" to indicate if you have any of the following:

	Yes	No		Yes	No
Bad breath	❑	❑	Fingernail biting	❑	❑
Bleeding gums	❑	❑	Food collection between teeth	❑	❑
Blisters on lips or mouth	❑	❑	Grinding teeth	❑	❑
Burning sensation on tongue	❑	❑	Gums swollen or tender	❑	❑
Chew on one side of mouth	❑	❑	Jaw pain or tiredness	❑	❑
Cigarette, pipe, or cigar smoking	❑	❑	Lip or cheek biting	❑	❑
Clicking or popping jaw	❑	❑	Loose teeth or broken fillings	❑	❑
Dry mouth	❑	❑	Orthodontic treatment	❑	❑
Pain around ear	❑	❑	Periodontal treatment	❑	❑
Sensitivity to cold	❑	❑	Sensitivity to heat	❑	❑
Sensitivity to sweets	❑	❑	Sensitivity to biting	❑	❑

Authorization

I certify that the above information is accurate to the best of my knowledge, and I agree to be treated by Dr. Petitto, his associates and the whole Petitto Family Dental staff. I further understand that payment is due at the time of service, and should it become necessary, any attorney fees, court costs, and collection fees become my responsibility and will be added to my account

I certify that I, and/or my dependent(s), have insurance coverage as described about and assign directly to Petitto Family Dental, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I have read a copy of this office's privacy practices, made available upon request.

Print Name____ Date ___/___/___

Signature ____