James Altomare D.D.S., P.A.

15 Tamarack Circle
Skillman, NJ 08558

Patient Registration

Today's Date: _____ Date of Birth:_____

Patient Name: (Last) _____ (First)_____ (M)_____
Home Address:_____ City_____ Zip_____
Home #:_____ Cell #:_____ Work#:_____
Occupation:_____ How Long Employed?_____
Sex: M or F Height_____ Weight_____ Marital Status: **Single Married Divorced Widowed**
Social Security #:_____ Driver License #:_____
Spouse's Name(parents name if child)_____ SS #:_____
Dental Insurance:_____ ID#:_____ Group #:_____
How did you hear about our office? :_____
E-mail address:_____

Medical History

General Health: **Excellent Good Fair Poor**
Name & Address of Physican:_____
Phone#:_____ Date of last complete physical? :_____
Are you taking **any** medication now? **YES or NO** If **YES** Name of medication and purpose:_____
_____

Have you ever had:

Heart Attack:	YES or NO	Hepatitis, jaundice or liver disease:	YES or NO
Heart Disease:	YES or NO	Fainting spell or seizures:	YES or NO
Angina(chest pain):	YES or NO	Hives or skin rash:	YES or NO
High or Low Blood Pressure:	YES or NO	Venereal disease or HIV+/AIDS:	YES or NO
Rheumatic Fever:	YES or NO	Diabetes:	YES or NO
Stroke:	YES or NO	Lung or Kidney disease:	YES or NO
Heart Murmur:	YES or NO	Emotional or nervous disorders:	YES or NO
Anemia or Blood disorders:	YES or NO	Glaucoma or eye disorders:	YES or NO
Cancer, tumors or growths:	YES or NO	Asthma, cough or sinus trouble:	YES or NO

Artificial Joints : Yes or NO If YES When?_____
Are there any other medical conditions you've had or have that are not listed above?_____
_____
Have you been hospitalized or had surgery in the last ten years?_____ When?_____ What for?_____
_____
Are you allergic to: Penicillin, Codeine, Local Anesthetics, Other Medication?_____
_____
Are you subject to prolonged bleeding? YES or NO
Are you pregnant? YES or NO How Long?_____

OVER

James Altomare D.D.S., P.A.

Dental Health

Reason for today's visit _____
Are you having any discomfort? YES or NO If yes, how long?_____
When was your last dental visit?_____ Dentist Name_____
Were x-rays taken?_____
Are you completely happy with the appearance of your teeth?_____
Would you like to have whiter teeth? _____
Do you have all of your teeth (other than wisdom teeth)?_____
Do your gums bleed easily?_____
Are any of your teeth sensitive to hot, cold or sweet foods or drinks?_____
Do you use dental floss daily? _____
Do you clench or grind your teeth while sleeping or during the day? _____
Are you free of "clicking" or "popping" in the ear region? _____
Do you suffer from frequent headaches or ringing in your ears? _____
Do you usually have many cavities? _____
Do you lose or break fillings? _____
Have you ever had orthodontics (braces)? _____
Do you want keep your own teeth as long as possible?_____
For routine dentistry, have you had Novocaine/Lidocaine? Never____ Sometimes _____ Always ____
Have you ever had nitrous oxide (laughing gas) analgesia? YES or NO
How often do you have your teeth cleaned? Every _____ months.

It would be helpful if you would indicate below what things you are looking for most in choosing your dentist and anything else you may feel is important.

_____
_____

Payment Policy- We are committed to providing you the best quality care. In order for us to serve you, we must agree on the following terms. Payment for services is due when rendered. If you have insurance we will assist you in obtaining benefits but you are responsible to pay the full costs of any procedure. We cannot guarantee any insurance coverage. You agree to pay interest at the rate of 1.5% per month on any remaining balance not paid within 30 days from the date of service. If we need to send your account to a collection agency or attorney an additional $50 charge will be added. Returned checks are subject to a $30 returned check fee.

Cancellation Policy- A charge will be made for failed or cancelled appointments without at least 48hrs notice. This fee ($75 per 15min.) covers only a portion of our overhead cost such as salaries, rent, taxes, insurance, electric etc, which still have to be paid whether you are present or not. Please remember, when an appointment is made you are reserving our time and we are reserving yours. Sufficient notice is needed so that we may schedule other patients. By signing below you agree with these terms.

Consent for Treatment

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

THANK YOU!

_____
(PATIENT OR PARENT SIGNATURE)