



JAMES ALTOMARE DDS

Our practice revolves around you.

Patient Registration

Today's Date: _____ Date of Birth: _____

Patient Name: (Last) _____ (First) _____ (M) _____

Home Address: _____ City _____ Zip _____

Home #: _____ Cell #: _____ Work#: _____

Occupation/Employer _____ 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 #: _____

E-mail address: _____

Emergency Contact Name _____ Phone# _____

Insurance Information

Not covered by dental insurance Yes___ No___

Subscriber Name: _____ Date of Birth: _____

Subscriber Social Security: _____ MemberID# _____

Dental Insurance Company: _____ Group# _____

Claims Address: _____

Medical History

General Health: **Excellent** **Good** **Fair** **Poor**

Name & Address of Physician: _____

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

OVER

PATIENT NAME: _____ DATE OF BIRTH: _____

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? _____

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.

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)