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 #:_____
E-mail address: _____
Spouse's Name (parents name if child)_____ SS #:_____
Emergency Contact Name_____ Phone#_____
Pharmacy name_____ Phone #_____

Insurance Information

Covered by dental insurance? Yes___ No___
Subscriber Name: _____Date of Birth: _____
Subscriber Social Security: _____MemberID#_____
Dental Insurance Company: _____ Group#_____

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

OVER

PATIENT NAME: _____DATE OF BIRTH: _____

Cigarette / Tobacco Use : YES or NO If YES, amount per day? _____
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 If Yes, How many weeks? _____

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)