

Gary Fiteny D.D.S..P.C. REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:		First:	Middle:	Birth date:	Social Security no.:
				/ /	
Home phone no.:	Alternate phone no.:	Street Address:			
()	()				
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.:			
		()			
Spouse's last name:		First:	Middle:	Birth date:	Social security no.:
				/ /	
Spouse's occupation:	Spouse's employer:	Employer address:			
Employer phone no.: ()		Spouse's dental insurance co.:			
Group number:			Phone no.: ()		
Name of nearest relative not living with you (Last/First/Middle):			Address:		Phone no.:
					()

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for account:	Birth date:	Address (if different):	Home phone no.:
	/ /		()
Occupation:	Employer:	Employer address:	Employer phone no.:
			()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate primary insurance:		Group number:	Phone no.: ()

DENTAL INFORMATION

Date of your last dental visit:	Purpose:
Date of your most recent full mouth radiographs:	May we request these radiographs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Dentist's name:	City:
Have you had any problems or complications with dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
Have you ever had orthodontics (braces)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Orthodontist:
Are you satisfied with the appearance of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are your teeth sensitive? <input type="checkbox"/> Yes <input type="checkbox"/> No	To what? <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize The offices of Gary Fiteny D.D.S..P.C. or the insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Gary Fiteny D.D.S..P.C.
REGISTRATION FORM (2)

(Please Print)

MEDICAL INFORMATION		
Physician's name:	City:	Phone no.: ()
Have you ever had an operation or serious illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	What and when?	
Are you currently being treated by a physician or specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	For what?	
Have you ever been premedicated for dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have any problems with antibiotics, anesthetics, or other medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Any allergies to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Medication name:	
Have you ever had any of the following? (check all that apply)		
<input type="checkbox"/> Cold sores <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Depression <input type="checkbox"/> AIDS/HIV+ <input type="checkbox"/> Psychiatric therapy <input type="checkbox"/> Hepatitis A B C <input type="checkbox"/> Heart surgery <input type="checkbox"/> Angina <input type="checkbox"/> Epilepsy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Tumor or malignancy <input type="checkbox"/> Radiation treatment <input type="checkbox"/> Neurological problems	<input type="checkbox"/> Diabetes <input type="checkbox"/> Allergies <input type="checkbox"/> Headaches <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Tuberculosis <input type="checkbox"/> High blood pressure <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Blood problems <input type="checkbox"/> Prosthetic joint <input type="checkbox"/> Nervous problems <input type="checkbox"/> Chiropractic care <input type="checkbox"/> Cancer <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Latex Sensitivity	<input type="checkbox"/> Dialysis <input type="checkbox"/> Ulcer <input type="checkbox"/> Kidney problems <input type="checkbox"/> Stroke <input type="checkbox"/> Jaundice <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart problems <input type="checkbox"/> Anemia <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Venereal disease <input type="checkbox"/> Periodontal disease
List all medications, drugs (including aspirin), vitamins, and herbal supplements you are currently taking:		
Do you currently smoke or use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No		
(Women only)	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Using oral contraceptives or hormone replacements? <input type="checkbox"/> Yes <input type="checkbox"/> No

NUTRITIONAL INFORMATION		
<input type="checkbox"/> Drink pop <input type="checkbox"/> Drink juice <input type="checkbox"/> Use antacids	<input type="checkbox"/> Drink coffee <input type="checkbox"/> Drink water <input type="checkbox"/> Eat candy	<input type="checkbox"/> Drink tea <input type="checkbox"/> Chew gum <input type="checkbox"/> Eat nuts
The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize The offices of Gary Fiteny D.D.S..P.C. or the insurance company to release any information required to process my claims.		
_____		_____
<i>Patient/Guardian signature</i>		<i>Date</i>