PATIENT REGISTRATION FORM

GREGORY J. PISANI, D.D.S.

This information is necessary for your health and our records, and will be considered confidential.

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI Preferred

Gender: _____ Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____ Best time to call: _____

Address: _____
Apartment #

_____
City State Zip code Email Address

Employer Name: _____ Occupation: _____

In case of emergency, call: _____ Relationship: _____ Phone: _____

If patient is a student, name of school: _____

Nearest Relative not living with you: _____ Relationship: _____ Phone: _____

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Is it ok to text you regarding appointment & patient information ☐ Yes ☐ No

MEDICAL HISTORY

Date of Last Dental Visit: _____ Previous Dentist: _____ Do you require pre-medication: ☐ Yes ☐ No

Have you ever had any of the following? Please check those that apply:

☐ AIDS / HIV	☐ Fainting	☐ Liver Disease	☐ S.T.I.
☐ Anemia	☐ Glaucoma	☐ Mental Disorders	☐ Tuberculosis
☐ Arthritis	☐ Growths	☐ Nervous Disorders	☐ Tumors
☐ Artificial Joints	☐ Hay Fever	☐ Osterporosis	☐ Ulcers
☐ Asthma	☐ Head Injuries	☐ Pacemaker	
☐ Cancer	☐ Heart Disease	☐ Radiation Treatment	
☐ Diabetes	☐ Hepatitis A B C	☐ Rheumatic Fever	FOR WOMEN
☐ Dizziness	☐ High Blood Pressure	☐ Sinus Problems	Are you pregnant? ☐ Yes ☐ No
☐ Epilepsy	☐ Jaundice	☐ Stomach Problems	Are you taking Birth Control pills? ☐ Yes ☐ No
☐ Excessive Bleeding	☐ Kidney Disease	☐ Stroke	

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of physician: _____ Phone: _____

Are you taking any of the following medications? ☐ Steroids ☐ Pain killers (including aspirin)

☐ Muscle relaxers ☐ Stimulants ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Bisphosphonates

☐ Other(s), please list: _____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Codeine

☐ Other(s), please list: _____

DENTAL HISTORY

- Are you experiencing any pain in any area of your mouth or teeth? ☐ Yes ☐ No
- Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No
- Are you worried or apprehensive about coming to the dentist? ☐ Yes ☐ No
- Have you had any problems with previous dental treatment? ☐ Yes ☐ No
- Have you had an unfavorable reaction to local anesthetic (xylocaine, novocaine, etc)? ☐ Yes ☐ No
- Have you been told you have a gum or bone problem? Clarify _____
- Have you lost many adult teeth? Why? _____

Do you have or have you had any of the following? Please check those that apply:

☐ FREQUENTLY BLEEDING GUMS	☐ FOOD CATCHING BETWEEN TEETH	☐ BURNING TONGUE OR MOUTH	☐ FREQUENT BAD BREATH
☐ EXTRACTION COMPLICATION	☐ SWELLING OR LUMPS IN MOUTH	☐ CLENCH OR GRIND TEETH	☐ PERIO TREATMENT
☐ UNPLEASANT TASTE	☐ MUSCLE SORENESS IN FACE OR NECK	☐ JAW POP OR CLICK	☐ ORTHO TREATMENTS
☐ PAIN AROUND EARS	☐ TEETH SENSITIVE TO HOT OR COLD	☐ INJURY TO FACE OR JAW	☐ FREQUENT HEADACHES

What dental aids do you use to clean your teeth? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

_____
Signature of patient, parent or guardian Date

REFERRAL

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Website ☐ Social Media ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

FINANCIAL INFORMATION

The following is for: ☐ The patient ☐ The person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (work): _____ Ext. _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip code

INSURANCE INFORMATION

Primary Are you covered by dental insurance? ☐ YES ☐ NO If yes, please complete this section.

Name of insured: _____

Last First MI

Insured's SS# _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip code

Insured's Employer Name: _____

Employer's Address: _____

Street City State Zip code

Patient's relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

CONSENT FOR SERVICE

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager.
- All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in cash at the time services are performed.
- Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
- If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account in addition to the principal amount due.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party