Date:_____

Drs. Louis & Dominic Vitangeli

Excellence in Restorative, Cosmetic & Implant Dentistry

PATIENT REGISTRATION

Your cooperation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is confidential and will remain with this office. We will be happy to assist you with completion of this form. **PLEASE PRINT**.

Patient's Name		Birth Date	Age	Sex: M F
Home Address	City	State	Zip	
Home Phone# _____ May we leave a message?	Prefers to be called: _____ Please Circle One: Single, Married, Separated, Widow		E-mail Address: Your Soc Sec. #	
Your Employer	Occupation		Cell Phone Work Phone	

Sometimes we need to contact you during the day. Please list, in order of availability, three numbers we can reach you at. Indicate if we will be calling your home, work, cell, etc.

( ) _____ - _____ ( ) _____ - _____ ( ) _____ - _____

Are you a full time student? ❑ Yes ❑ No *If patient is minor we need: Mother's Birth Date* _____ *Father's Birth Date* _____

Person responsible for account

Name of spouse (Parent if minor) E-mail address Cell Phone

Spouse's (parent's) employer Spouse's Soc. Sec. # Work Phone

EMERGENCY INFORMATION

Name, Address, & Telephone of A Relative Not living with you. *Relationship*

How did you hear about our office?

Whom may we thank for referring you? ❑ Yellow Pages ❑ Office Sign Church Bulletin _____ St. Paul's _____ St. Rita's _____ Precious Blood ❑ Direct Mail ❑ Other _____

Reason for this visit?

DENTAL INSURANCE INFORMATION (Primary Carrier)	If you have a dual insurance coverage, complete this for the second coverage
Insured's name DOB SS#	Insured's name DOB SS#
Insured's employer	Insured's employer
Insurance Co.	Insurance Co.
Insurance Co. Address	Insurance Co. Address
Phone #	Phone #
Group # Local #	Group # Local #

Is there any other medical or dental information we should know about?

Patient Signature (Parent of Child) Date Dentist Signature

DENTAL HISTORY

Please check any of the following that apply to you.

Sensitivity (hot, cold, sweet) ❑
Where? UR LR UL LL
Headaches, earaches, neck pain ❑
Jaw joint pain ❑
Teeth or fillings breaking ❑
Grinding or clenching teeth ❑
Bleeding, swollen or irritated gums ❑
Loose, tipped or shifting teeth ❑
Bad breath ❑

Do you have or have you had any of the following?

Dentures ❑
Partial dentures ❑
Braces ❑
Gum treatments ❑

Please share the following dates:

Your last cleaning ___ / ___
Your last oral cancer screening ___ / ___
Your last complete X-Rays ___ / ___

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it? ❑

Do you smoke or use chewing tobacco ❑
How much? For how long?

If I could change my smile, I would: ❑
-Make them whiter ❑
-Make them straighter ❑
-Close spaces ❑
-Replace black metal fillings with tooth colored restorations ❑
-Repair chipped teeth ❑
-Replace missing teeth ❑
-Replace old crowns that don't match ❑
-Have a smile makeover ❑

On a scale of 1 - 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you.

❑ Allergies (Seasonal)
❑ Anemia
❑ Arthritis
❑ Artificial Heart Valve
❑ Artificial Joints
❑ Asthma
❑ Blood Disease
❑ Bruise Easily
❑ Cancer
❑ Chemotherapy
❑ Diabetes
❑ Dizziness
❑ Drug Addiction
❑ Emphysema
❑ Excessive Bleeding
❑ Fainting
❑ Glaucoma
❑ Heart Conditions
❑ Heart Lesions (Congenital)
❑ Heart Murmur
❑ Heart Surgery
❑ Hepatitis A
❑ Hepatitis B
❑ Hepatitis C
❑ High Blood Pressure
❑ Jaundice
❑ Jaw Joint Pain
❑ Kidney Disease
❑ Liver Disease
❑ Low Blood Pressure
❑ Mitral Valve Prolapse
❑ Nervousness/Depression
❑ Pacemaker
❑ Phen Fen (1 month +)
❑ Radiation (head/neck)
❑ Respiratory Problems
❑ Rheumatic Fever
❑ Rheumatism
❑ Scarlet Fever
❑ Seizures
❑ Stomach Problems
❑ Stroke
❑ Thyroid Disease
❑ Tuberculosis
❑ Ulcers
❑ Venereal Diseases
❑ Other

For WOMEN Only

❑ Birth Control Pills
❑ Breast-feeding
❑ Pregnant
1-3 mos, 3-6 mos, 6-9 mos,

Do you have any of the following drug allergies?

❑ Aspirin
❑ Darvon
❑ Erythromycin
❑ Local Anesthetic
❑ Nitrous Oxide
❑ Penicillin
❑ Percodan
❑ Valium
❑ Other _____

Are you under a physician's care? ____ Yes ____ No

If Yes: Reason _____

_____

Family Physician **Phone Number**

_____ _____

Medications you are currently taking: _____ _____

_____ _____ _____