DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

2 DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext_____ Spouse's Work_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 DENTAL HISTORY

Reason for today's visit_____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental X-rays_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss?_____

How often do you brush?_____

5 HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swelling of Feet or Ankles	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Do you wear contact lenses?	☐ Yes ☐ No	Women:		Weight Loss, unexplained	☐ Yes ☐ No
		Are you pregnant?	☐ Yes ☐ No		
		Due date_____			
		Are you nursing?	☐ Yes ☐ No		

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Members: consider using this sample Consent Form prepared courtesy of NYSDA.

GENERAL DENTISTRY CONSENT FORM

DR. DANIEL J. GATTEGNO
173 WEST 81ST STREET, SUITE 1E
NEW YORK, NY 10024
(212) 724-2195

Dentist:_____ Patient:_____

Dentistry is not an exact science and reputable practitioners cannot properly guarantee results. Despite the most diligent care and precaution, unanticipated complications or unintended results, although rare, may occur. A treatment plan is based on the best evidence available during the examination. There is no guarantee that this plan will not change. During treatment, it may be necessary to change or add procedures because of conditions that were not evident during examination, but were found during the course of treatment. For example, root canal treatment may be needed during routine restorative procedures. Any change in treatment plan may result in additional fees.

Guarantees and assurances cannot be made by anyone regarding the dental treatment which you have requested and authorized. It is essential that you keep your appointments and cooperate in your treatment to help insure the best possible result. Please read the following and initial and sign where noted.

SERVICES THAT MAY BE PROVIDED INCLUDE THE FOLLOWING

1. FILLINGS

Care must be exercised in chewing on filled teeth, especially on large fillings and during the first 24 hours, to avoid breakage. A more extensive restorative procedure than originally diagnosed may be necessary, due to more decay than anticipated. Sensitivity can occur following a newly placed filling and will usually go away with time.

(Initials _____)

2. CROWNS, BRIDGES AND LAMINATES

These restorations involve permanent alteration of the tooth structure. It is not always possible to match the color of the natural teeth exactly with artificial teeth. Temporary restorations may come off easily. Care must be taken to insure that they are kept on until the permanent restorations are delivered. The final opportunity to make changes to the new crowns, bridges or laminates (including the shape, fit, size and color) will be before cementation. It is necessary to keep the appointment for permanent cementation. Excessive delays may allow for tooth movement, necessitating the remaking of the restoration and additional charges may be incurred.

(Initials_____)

3. DENTURES (FULL AND PARTIAL)

The wearing of dentures can be difficult. Sore spots, altered speech and difficulty in eating are common problems. Due to jaw ridge loss, retention of full dentures can be a problem. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later (this is not included in the denture fee). You are responsible to return for delivery of the dentures. Failure to do so may result in poorly fitting dentures and remakes will require additional charges. Failure to wear partial dentures every day will likely lead to tooth movement, resulting in a partial that no longer fits.

(Initials_____)

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4. PERIODONTAL DISEASE

Periodontal disease affects the gums and bone which support the teeth. It is a serious, progressive infection, causing breakdown of the gums and bone and eventual loss of teeth. It is best treated in its early stage. Treatment options may include gum surgery, extractions and replacements. Undertaking any dental procedure may have a future adverse effect on the periodontia.

(Initials_____)

5. ENDODONTIC TREATMENT (ROOT CANAL)

Although over 90% effective, there is no guarantee that root canal treatment will succeed and complications can occur from the treatment. Endodontic files and reamers are very fine instruments and can separate during use. Additional surgical procedures may be necessary following root canal treatment. Despite all efforts to save it, the tooth may still be lost.

(Initials_____)

6. REMOVAL OF TEETH (EXTRACTIONS)

Teeth may need to be extracted for various reasons, such as non-restorability, lack of bone support, part of orthodontic treatment, impactions, etc. There are alternatives to the removal of treatable teeth and these options include root canal treatment, periodontal treatment and crowns. Removal of teeth does not always remove the infection, if present, and further treatment may be necessary. There are risks involved in having teeth removed, including, but not limited to pain, swelling, spread of infection, dry socket, loss of feeling in the teeth, lips, tongue and surrounding tissues (*which is usually temporary, but in rare cases is permanent*), sinus involvement and jaw fracture. If complications arise during or following treatment, referral to a specialist may be needed, requiring further treatment and additional cost.

(Initials_____)

7. DRUGS, MEDICATIONS, AND ANESTHETICS

Antibiotics, analgesics, natural supplements and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting and/ or anaphylactic shock. Injections of local anesthetics can cause paresthesia (numbness) of teeth, lips and surrounding tissues. Though quite rare, this numbness can sometimes be permanent. Studies have shown that Bisphosphonate (ex. Fosomax) therapy for osteoporosis can compromise treatment results.

(Initials_____)

_____

Signature of Patient Date

_____

Signature of Dentist Date