

**PATIENT REGISTRATION**

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Social Security# \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Student Status: \_\_\_ Full time \_\_\_ Part time Name of School: \_\_\_\_\_

**SPOUSE/PARENT/GUARDIAN RESPONSIBLE FOR ACCOUNT:**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Social Security# \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Business Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Seasonal Resident? Y or N Date you leave \_\_\_\_\_ Date you Return \_\_\_\_\_  
Seasonal Out of Town Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**WHO DO WE CONTACT IN CASE OF EMERGENCY:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Closest Relative Not Living With You \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE AUTHORIZATION:**

I hereby authorize Dr. Charles Tomeo to furnish information to my insurance carriers concerning my treatments, and I hereby assign to them all payments for services rendered to Dr. Tomeo. I understand that I am responsible for any amount not covered by the insurance.

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.**

**Signature below is for acknowledgement that the above information is correct and that you have received this Notice of our Privacy Practices:**

Signature \_\_\_\_\_ Print Name: \_\_\_\_\_  
Date: \_\_\_\_\_

# HEALTH HISTORY

Patient's Name	Date of Birth	Height	Weight	Date
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Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam \_\_\_\_\_
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

- I. Are you taking or **have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)? ..... Y N
- J. Have you ever been advised not to take a medication? ..... Y N
- K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
  - A. Rheumatic Fever or Rheumatic Heart Disease?..... Y N
  - B. Congenital Heart Disease? ..... Y N
  - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
  - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
  - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Y N
  - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
  - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
  - H. Kidney Disease? ..... Y N
  - I. Diabetes? ..... Y N
  - J. Thyroid Disease (Goiter)? ..... Y N
  - K. Arthritis? ..... Y N
  - L. Stomach Ulcers or Colitis? ..... Y N
  - M. Glaucoma? ..... Y N
  - N. Osteoporosis? ..... Y N
  - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
  - A. Local Anesthesia (Novocain, etc.)? ..... Y N
  - B. Penicillin or other antibiotics? ..... Y N
  - C. Sedatives, Barbiturates? ..... Y N
  - D. Aspirin or Ibuprofen? ..... Y N
  - E. Codeine or other painkillers? ..... Y N
  - F. Latex or Rubber products? ..... Y N
  - G. Metal of any kind? ..... Y N
  - H. Chemicals or jewelry (rash or sensitivity)? ..... Y N
  - I. Food products? ..... Y N
  - J. Other allergies or reactions? Please list ..... Y N

7. **ARE YOU USING ANY OF THE FOLLOWING:**
  - A. Antibiotics? ..... Y N
  - B. COUMADIN OR PLAVIX? ..... Y N
  - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
  - D. High Blood Pressure medications? ..... Y N
  - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
  - F. Tranquillizers? ..... Y N
  - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
  - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N

9. Do you smoke or chew Tobacco? ..... Y N  
How much per day? \_\_\_\_\_
10. Is there any past history of Alcohol or Chemical? Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
11. Have you had any serious problems associated with any previous dental treatment? ..... Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
14. Do you wish to talk to the doctor privately? about anything? ..... Y N
15. Have you ever had a bone density scan? ..... Y N
16. **FOR WOMEN ONLY**
  - A. Are you Pregnant, or **is there any chance** you might be Pregnant? ..... Y N
  - B. Are you nursing? ..... Y N
  - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date _____	Signature of Person Completing Health History _____	Doctor's Initials _____
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Medical Update: I have read my Health History dated \_\_\_\_\_ and confirm that it adequately states past & present conditions.

Date _____	Exceptions or changes _____	Patients signature _____	Doctor _____
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