PATIENT REGISTRATION

DATE:_____ Home Phone: _____ Cell Number: _____
Name : _____
Address: _____ _____City: _____
State: _____ Zip: _____Social Security Number: _____
EMAIL : _____
Birthdate: _____Sex: ___ Single:___ Married:___ Divorced: ___ Widowed:
Employer: _____ Business Phone: _____
Dental Insurance: _____Phone Number: _____
Insurance Address: _____City: _____
State:_____ Zip Code: _____ ID#: _____ Group #: _____
Spouse Name: _____ Spouse#: _____
In case of an Emergency, who should be notified: _____Phone: _____
Whom may we thank for referring you: _____Phone: _____

MEDICAL HISTORY

Physician Name: _____Office Phone: _____
Date of last exam: _____

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Have you ever had any of the following? (Please circle what applies)

Heart Problems	**Cancer**	**BACK Problems**	**Stroke**
High / Low Blood Pressure	**Radiation/Chemo Treatment**	**Epilepsy**	**Ulcer**
Neck / Jaw Problems	**Allergies to Medications**	**Head Aches**	**Hemophilia**
Swollen Neck Glands	**Allergies to Anesthetics**	**Chronic Diarrhea**	
Artificial Valve/Joints	**General Allergies**	**Recent Weight Loss**	
Diabetes	**Sinus Problems**	**AIDS/ Immune Disorder**	
Arthritis	**Hepatitis / Jaundice**	**Psychiatric Care**	
Respiratory Disease	**Blood Disease**	**Nervous Problems**	
Circulatory Disease	**Special Diet**	**Other:_____**	

List medications you are taking at this time: _____
Do you have any medication allergies? _____If yes, what? _____
Tobacco use? _____If so, what kind and how much? _____
Unusual Reaction to dental injections? _____
(WOMEN) Do you suspect you are pregnant? _____ Nursing? _____
Reason for today's visit? _____ Are you in pain? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his staff for any errors or omissions that I may have made in the completion of this form. I am aware that after 60 days a 1.5 % finance charge will be charged monthly. I consent for the office to contact me via telephone, email, fax or mail. I authorize and direct payment of the dental benefits directly to Dr. James Gesiotto.

Name: _____ Date: _____