Vezzetti Family Dental Care Registration

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

About You:

Name: ____ Birth Date: _______/_______/______________

Preferred Name: ______________________________________ ☐ Female ☐ Male

Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Child

Social Security Number: (Information needed to bill insurance) ____

Address: ____

City: ____ State: _____________________ Zip: ________________

Home Phone: ___________________________________ Cell Phone: ___________________________________

Employer: _______________________________________ Work Phone: _________________________________

Email Address: ____

Names of Family Members: ____

Last Dentist/Location: ____

Last Dental Visit: ____ Last Dental X-Rays: _______________________

How did you hear about our Office? ____

Do you have any Dental Concerns? ____

____

Emergency Information:

Person to Contact: ____________________________________ Relationship: ____________________________

Phone Number: ____

Insurance Information:

Policy Holder: ____ Birth Date: ________/_______/_____________

Policy Holder's SSN: _____________________________ Policy Holder's Employer: ________________________

Insurance Company Name: ____

Insurance Company's Phone: ____

Member ID: ______________________________________ Group Number: _________________________________

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Vezzetti Family Dental Care.

Patients Initials: ______

Medical History

Name: ____ Birth Date: ______________________________

Personal Physician: ____________________________ Physician's Number: _______________________
When was your last physical? ____________________________

Have you been hospitalized in the last five (5) years? If yes, please explain: ________________________________

(For Women) Are you currently Pregnant? ☐ YES ☐ NO If yes, How many months? ______________

Do you have Acid Reflux? ☐ YES ☐ NO

Have you ever taken **ANY** bone saving drugs (ex: Boniva, Fosamax)? ☐ YES ☐ NO If yes, Please list: _______________

____

Please list ANY medication, pills, vitamins, or drugs you are taking: ____

____

____

Do you require Pre-Medication for dental appointments? ☐ YES ☐ NO **Do you use tobacco?** ☐ YES ☐ NO

Please check if you are allergic to any of the following:

☐ Local Anesthetics ☐ Sulfa Drugs ☐ Codeine ☐ Penicillin ☐ Acrylic ☐ Metal ☐ Latex

☐ Other, please explain: ____

Do you have, or have you had, any of the following:

☐ ADHD/Autism/Asperger's	☐ Cortisone Medicine	☐ Hemophilia	☐ Psychiatric Care
☐ AIDS/HIV Positive	☐ Diabetes	☐ Hepatitis A or B or C	☐ Rheumatic Fever
☐ Allergies	☐ Drug Addiction	☐ High/Low Blood Pressure	☐ Osteoporosis
☐ Alzheimer's Disease	☐ Emphysema	☐ Hives/Rash	☐ Shingles
☐ Anaphylaxis	☐ Epilepsy/Seizures	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Arthritis/Rheumatism/Gout	☐ Excessive Bleeding	☐ Kidney Disease/Dialysis	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Excessive Thirst	☐ Leukemia	☐ Skin Disorder
☐ Artificial Joint_______________	☐ Fainting Spells/Dizziness	☐ Liver Disease	☐ Spina Bifida
☐ Asthma	☐ Frequent Cough	☐ Lung Disease	☐ Stroke
☐ Anxiety	☐ Gastrointestinal Disease	☐ Migraines/Headaches	☐ Tonsillitis
☐ Blood Transfusion	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Bruise Easily	☐ Heart Attach/Failure	☐ Multiple Sclerosis	☐ Tumors or Growth
☐ Cancer ______________	☐ Heart Defibrillator	☐ Neurological Disease	☐ Ulcers
☐ Chemotherapy/Radiation	☐ Heart Disease	☐ Pain in Jaw Joints	☐ Venereal Disease
☐ Chest Pains	☐ Heart Murmur	☐ Parathyroid /Thyroid Disease	
☐ Cold Sores/Fever Blisters	☐ Heart Pace Maker	☐ Parkinson's	

Have you ever had any serious illness not listed above? If yes, please explain: ___________________________________

____

The information that I have given is true and accurate to the best of my knowledge.

Signature: ____ Date: ___________________________

Communication of Health Information, Appointment Reminder, and Discussion of Treatment and Financial Authorization

Name: ____ Birth Date: ________________

I give Vezzetti Family Dental Care permission to leave a message and release information via the following methods:

☐ Cell Phone: __________________________ Voicemail? ☐ YES ☐ NO

Text Message? ☐ YES ☐ NO

Leave Verbal Message with: ______________________________________

☐ Home Phone: __________________________ Voicemail? ☐ YES ☐ NO

Leave Verbal Message with: ______________________________________

☐ Work Phone: __________________________ Voicemail? ☐ YES ☐ NO

Leave Verbal Message with: ____

☐ Email: ____

I give Vezzetti Family Dental Care permission to discuss matters VERBALLY and WRITTEN pertaining to my dental health and account information with:

Name: ______________________________ Relationship: _______________________

Home/Cell Phone: ______________________ Work Phone: _______________________

Name: ______________________________ Relationship: _______________________

Home/Cell Phone: ______________________ Work Phone: _______________________

Signature: __________________________________ Date: ___________________

I give Vezzetti Family Dental Care permission to administer treatment to my child under the age of 18 without my presence.

Patient: ___________________ Guardian Signature__________________ Date: ____________

Unless otherwise requested; we remind you of upcoming appointments via letter, phone calls, text, voicemails, emails, and/or a verbal message with the person who answers your phone. Appointment reminders include date and time of your appointment. I understand that this will authorize the release of my information in the manner stated above. I understand this consent will remain in effect until written notification is given to cancel this request