

Joe D. Arbutante D.D.S. Family Dentistry
REGISTRATION

Today's Date: _____ How did you hear about our office? _____

What is the reason for your visit today? _____

Name: _____ Marital Status: S M W D SEP

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone : _____

Cell Phone: _____ E-mail address: _____

Can we text__ and/or e-mail __ your appointments reminders: Yes No

Birthdate: _____ Social Security No.: _____

Occupation: _____ Place of Employment _____

If Married, Name of Spouse: _____

If Married, Occupation of Spouse: _____

If Married, Spouses place of employment: _____

Spouses work Phone No.: _____

Child's Mother's Name _____ Employment: _____

Occupation _____ Contact # _____

Child's Father's Name _____ Employment _____

Occupation _____ Contact # _____

Family Physician: _____

DENTAL INSURANCE INFORMATION

Primary

Secondary

Subscriber's Name: _____ - _____

Birthdate: _____ - _____

Social Security No. _____ - _____

Employer: _____ - _____

Dental Ins. Co.: _____ - _____

Group/Policy No.: _____ - _____

EMERGENCY INFORMATION

Name of the person to contact in the case of an emergency **outside** of the household: _____
 Address: _____ City: _____
 Telephone: _____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor in the past 2 years? Yes No
 If yes, for what? _____

2. Physicians Name _____

3. Are you currently taking any medications, drugs, or pills? Yes No
 If yes, please list:

4. Are you aware of having an **allergic or adverse reaction** to any medication or substance? Yes No Please List: _____

5. Indicate which of the following you have had, or have at the present:

Heart (surgery,disease,attack)	Y	N	Stroke	Y	N
Chest Pain	Y	N	Diabetes	Y	N
Congenital Heart Disease	Y	N	Asthma	Y	N
Heart Murmur/mitral valve prolase	Y	N	Hay Fever	Y	N
Artificial Heart Valve	Y	N	Allergies / Hives	Y	N
Heart Pacemaker	Y	N	Radiation Therapy	Y	N
High Blood pressure	Y	N	Chemotherapy	Y	N
Arthritis/Rheumatism	Y	N	Tumors/ Cancer	Y	N
Swollen ankles	Y	N	Hepatitis A/B/C	Y	N
Fainting or Dizzy spells	Y	N	Blood thinner/Aspirin	Y	N
Artificial Joints (hip,knee)	Y	N	Venereal Disease	Y	N
Kidney Trouble	Y	N	H.I.V. Positive	Y	N
Cold Sores/Fever Blisters	Y	N	A.I.D.S.	Y	N
Thyroid Problems	Y	N	Blood Transfusion	Y	N
Liver Disease	Y	N	Hemophilia	Y	N
Epilepsy or Seizures	Y	N	Bruise Easily	Y	N
Tuberculosis	Y	N	LATEX allergy	Y	N
Heart Stents	Y	N	Sulfa allergy	Y	N
Depression	Y	N	Sulfer allergy	Y	N
Codeine allergy	Y	N	Penicillin allergy	Y	N

6. Do you have any disease or condition not listed? Yes No
 If yes, please list: _____

7. WOMEN ONLY

Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Financial Policy

To keep your dental care affordable, we require payment at the time of service

Dental Insurance

We participate with Blue Cross/Blue Shield, Delta Dental, and Cigna Dental. But if you have any other dental insurance, we will gladly submit your claim on your behalf. Your dental plan is designed to share your dental costs and may not cover the total cost of your treatment. Most dental plans cover between 50% to 80% of dental services. Your remaining co-pay is required at the time of service. We do our best to determine your coverage, but we **cannot guarantee** any estimated coverage. Your dental insurance policy is an agreement between you and your insurance carrier. Please ask your employer regarding any questions about your coverage. If your insurance company has not paid its portion in **30 days** from treatment, you will be responsible for all of the remaining balance. We will gladly assist you in re-submitting your claim to your dental insurance.

Payment Options and Financing

Every person's financial situation is different, and therefore we provide several payment options.

1. For treatment paid in full with cash, check or debit card, we offer a 5% accounting reduction, at the time scheduling the appointment.
2. For your convenience, we accept cash, check, Discover Card, Visa, MasterCard, and debit cards.
3. If you would like up to 12 months interest free payments, we offer Care Credit that provides dental financing for your treatment. For more information or to apply, go to www.CareCredit.com or call at 1-800-365-8295.

We are here to help you get the quality dental care you may need or want. If you have any questions or concerns, please call us and we will be more than willing to help you.



SMILE EVALUATION

1. Do you like the way your teeth look? Yes _____ No _____

Explain: _____

2. Are you happy with the color of your teeth? Yes _____ No _____

Explain: _____

3. Would you like for your teeth to be whiter? Yes _____ No _____

Explain: _____

4. Would you like your teeth to be straighter? Yes _____ No _____

Explain: _____

5. Do you have spaces between your teeth that you would like closed? Yes _____ No _____

If so, where? _____

6. Would you like your teeth to be longer? Yes _____ No _____

Explain: _____

7. Do you like the shape of your teeth? Yes _____ No _____

Explain: _____

8. Do you have missing teeth that you like to replace? Yes _____ No _____

Explain: _____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes _____ No _____

Explain: _____

10. If you could change anything about your smile, what would you change?

11. Do you have any concerns or fears about having any dental treatment? Yes _____ No _____

Explain: _____

