TODAY'S DATE

GARY M. CARMASSI, DMD

REGISTRATION HISTORY

PATIENT NAME	DATE OF BIRTH	MARITAL STATUS
E-MAIL ADDRESS	MAY WE E-MAIL STATEMENTS TO YOU?	
STREET ADDRESS	CITY STATE	ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE
PRIMARY DENTAL INSURANCE	PRIMARY ID NUMBER	
SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	
SECONDARY DENTAL INSURANCE	SECONDARY ID NUMBER	
SUBSCRIBER NAME (SECONDARY)	SUBSCRIBER DATE OF BIRTH (SECONDARY)	
EMERGENCY CONTACT NAME, PHONE NUMBER, RELATIONSHIP		
KNOWN DRUG ALLERGIES	DO YOU TAKE OSTEOPOROSIS DRUGS SUCH AS: FOXAMAX, ATONEL, BONIVA, RECLAST?	
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		
NAME OF PHYSICIAN	PHYSICIAN PHONE NUMBER	

CURRENT MEDICATION	DOSAGE	FREQUENCY
CURRENT MEDICATION	DOSAGE	FREQUENCY
CURRENT MEDICATION	DOSAGE	FREQUENCY
CURRENT MEDICATION	DOSAGE	FREQUENCY

DATE OF LAST DENTAL TREATMENT_____

ANY DISCOMFORT IN JAW JOINTS OR EARS WHEN CHEWING?_____

DO YOU CLENCH OR GRIND YOUR TEETH?_____

DO YOUR GUMS BLEED WHEN CHEWING OR BRUSHING?_____

HAVE YOU EVER HAD RADIATION TREATMENT?_____

HAS A PHYSICIAN PRESCRIBED ANTIBIOTIC MEDICATION PRIOR TO DENTAL TREATMENT? _____WHY?_____

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ARE YOU NOW OR HAVE YOU RECENTLY BEEN UNDER THE CARE OF A PHYSICIAN? _____WHY? _____

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