



Anthony Zamany, D.D.S., M.S.D.

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Name _____
LAST FIRST MI

Mr. Mrs. Ms. Dr.

Address _____

CITY STATE ZIP

Sex M F Birthdate _____

Patient Employer _____

Occupation _____

Employer Address _____

2 DENTAL INSURANCE

Primary Insurance Co. _____

Subscriber's Name _____

Subscriber's Birthdate _____

Relationship to Patient _____

Group # _____

ID/SS# _____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

3 CONTACT INFORMATION

Home _____ Work _____ Ext _____ Cell _____ Email _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____ Phone _____

4 HEALTH HISTORY

Physician's Name _____ Phone _____

Have you ever taken Fosamax or Actonel for treatment of osteoporosis? Yes No

Place a mark on "yes" or "no" to indicate if you had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Abnormalities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No

ANY OTHER MEDICAL HISTORY THAT WE SHOULD KNOW?

WOMEN ONLY: Are you pregnant? Yes No How Many Months? _____

Are you nursing? Yes No Taking Birth Control Pills? Yes No

MEDICATIONS: List any medications you are currently taking: _____

ALLERGIES:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthesia	<input type="checkbox"/> Barbiturates
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex	<input type="checkbox"/> Other

5 DENTAL HISTORY

Reason for today's visit _____

Current Dentist _____ City/State _____

The above information is accurate and up to date to the best of my knowledge.

Signature (if minor, guardian's signature) _____ Date _____