PATIENT REGISTRATION (PLEASE PRINT)

BART RIZZUTO, D.D.S **ROBERT W. BERLS, D.D.S.**

Date_____ Single___ Married___ Widowed___ Separated___ Divorced___

PATIENT INFORMATION

Patient's Name _____ Birthdate_____
Address_____
City_____ Zip Code_____
Home Phone_____ Cell Phone_____
Referred By_____
Dentist Name_____
Employer_____
Occupation_____ Work Phone_____
Address_____

SPOUSES INFORMATION

Spouses Name_____
Employer_____
Occupation_____
Work Phone_____ Birthdate_____
Address_____

Who is responsible for this account:

_____

DENTAL INSURANCE INFORMATION

PRIMARY:

Name of Insurance Company_____ Name of Insured_____
Relation to Patient_____ SS#_____ Group#_____
Address_____

SECONDARY:

Name of Insurance Company_____ Name of Insured_____
Relation to Patient_____ SS#_____ Group#_____
Address_____

MEDICAL HEALTH HISTORY

Physicians Name_____ Date of Last Exam_____
Have you been treated for any Medical Problems in the past five years? YES___ NO___. Please Explain:

_____

Have you ever been hospitalized___YES____NO. If so, for what_____
Are you taking any Medications?___YES____NO. Please List_____
Do you need to premedicate before dental procedures___YES____NO Name of Medication_____
Do you have any artifical joints, heart valves, or a pacemaker? If so describe_____
Are you allergic to any medications___YES____NO. If so, please Name_
Do you have or have you ever had any of the following? Please check YES or No:

YES	NO		YES	NO		YES	NO	
___	___	Any Heart Problems	___	___	Anemia	___	___	Allergy to Anesthetics
___	___	Heart Murmur	___	___	Diabetes	___	___	Allergy to Medications
___	___	Rheumatic Fever	___	___	Arthritis/Rheumatism	___	___	Other Allergies
___	___	Heart Attack/Angina	___	___	Epilepsy	___	___	Cancer
___	___	Lung/Breathing Problems	___	___	Stroke	___	___	High Blood Pressure
___	___	Asthma	___	___	Tuberculosis	___	___	Low Blood Pressure
___	___	Stomach/Intestinal Problem	___	___	Seizures	___	___	(woman) Are you Pregnant?
___	___	Reflux/Gerd	___	___	Kidney Problems	___	___	Bruxism/Grinding Teeth
___	___	Circulatory Problems	___	___	HIV	___	___	TMJ Problem
___	___	Bleeding Problems	___	___	Liver/Hepatitis			

Is there anything else not mentioned? _____

Your insurance is a method for you to receive reimbursement for fees you have paid to the dentist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based upon your contract with them, not our office. We will do all we can to assist you in receiving reimbursement, but you are responsible for your bill.

SIGNATURE ON FILE_____ **DATE**_____