Richard F. Amato DDS
Patient Registration and Medical History

Date_____ Home Phone_____ Work Phone_____

Last Name_____ First Name_____ Preferred Name_____

Street Address_____ City _____ State_____ Zip_____

Sex: ❑M ❑ F Age_____ Date of Birth _____ Social Security #_____-_____-_____

❑Minor ❑Married ❑Single ❑Divorced ❑Widowed

Driver's License # _____E-Mail Address_____

Employer_____ Address_____ Occupation_____

Spouse/Parent Name_____ Date of Birth _____Social Security #_____-_____-_____

Spouse Employer_____ Address _____Business Phone_____

PATIENT: Dental Insurance Company_____

SPOUSE: Dental Insurance Company _____

Who is responsible for this account? _____ Relation to Patient_____

In Case of Emergency Call_____ Phone_____

Referring Doctor or Patient_____

Medical History

Physicians Name _____ Phone _____ Date of Last Physical_____

PLEASE CHECK BOXES THAT APPLY:

❑ Cardiovascular Disease	❑ Hepatitis	❑ Rheumatic Fever / MVP	❑ Stroke
❑ High/Low Blood Pressure	❑ Cancer	❑ Sinus Problems	❑ Allergies to Anesthetics/Drugs
❑ Diabetes	❑ Arthritis	❑ AIDS-HIV	❑ Chemical Dependency/Treatment
❑ Respiratory Disease	❑ Tuberculosis	❑ Blood Dyscrasia	❑ Smoker
❑ Epilepsy	❑ General Allergies	❑ Venereal Disease	❑ Pregnant / Nursing

❑ ANY OTHER MEDICAL CONDITION - **PLEASE LIST**_____

Do you have any allergies or have you ever had an adverse reaction to medication? ❑Yes ❑No

If yes what? _____

Have you ever responded adversely to medication or dental treatment? ❑Yes ❑No

If yes what? _____

Are you under the care of a physician ? ❑Yes ❑No If yes Who?_____

For what conditions?_____

Are you taking any medications? Please list. _____

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I understand that insurance coverage is a contract between my insurance carrier and myself. As a courtesy Dr. Amato's office will submit all necessary information. After 60 days the balance becomes my sole responsibility. After 90 days there will be a 1.5 % monthly interest charged.

Date_____Signature_____