

PATIENT REGISTRATION:

Pamela Z. Baldassarre, D.M.D. Practice Limited to Periodontology

Date: _____

Name: *Dr/Mr/Mrs/Ms/Miss* _____

Address: _____

City: _____ State: _____ ZipCode: _____

Home Phone:()-_____ Work Phone:():_____ ext:_____

Birth date:_____ SSN:_____ Nickname:_____

Referring Dentist:_____ Physician:_____

Person to contact in emergency:_____

Primary DENTAL INSURANCE INFORMATION

Plan Description: _____

(Ins. Co.) Address: _____

Insured Party:_____ DOB:_____

Insured Party ID:_____ Insured Party SSN:_____

Employer Name: _____

Group No:_____ Group Name:_____

Policy Start Date:_____ Policy End Date _____

Deductible Met:_____ Annual Maximum:_____

Secondary DENTAL INSURANCE INFORMATION

Plan Description: _____

(Ins. Co.)Address: _____

Insured Party:_____ DOB:_____

Insured Party ID:_____ Insured Party SSN:_____

Employer Name: _____

Group No:_____ Group Name:_____

Policy Start Date _____ Policy End Date:_____

Deductible Met:_____ : Annual Maximum _____

:

HEALTH QUESTIONNAIRE

ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE

Patient's Name: _____ Date: _____

Dentist's Name: _____ Phone Number: _____

Physician's Name: _____ Phone Number: _____

Date of Last Physical: _____

*Many medical problems can affect your periodontal health even though they seem unrelated to you.
Please answer the following as accurately as possible.*

Have you ever had or do you have any of the following?

Explain/Comments

	No	Yes	
1. Rheumatic Fever	No	Yes	
2. Heart Trouble	No	Yes	
3. Heart Murmur	No	Yes	
4. Have you taken PHEN PHEN?	No	Yes	
5. Bleeding Problem	No	Yes	
6. High Blood Pressure	No	Yes	
7. Anemia	No	Yes	
8. Diabetes	No	Yes	
9. Fainting Spells	No	Yes	
10. Asthma	No	Yes	
11. Lung Trouble	No	Yes	
12. Tuberculosis	No	Yes	
13. Hepatitis Type _____	No	Yes	
14. AIDS/HIV	No	Yes	
15. Epilepsy	No	Yes	
16. Concussion	No	Yes	
17. TMJ Problem or pain	No	Yes	
18. General Anesthesia	No	Yes	

