Steve P. Purtell, D.D.S. • Christopher G. Vitagliano D.M.D.

6945 East Sahuaro Drive, Suite B2
Scottsdale, Arizona 85254
(480) 443-3339

Date_____

PATIENT'S REGISTRATION AND HISTORY

PLEASE PRINT

Patient's Name_____ Name wished to be called_____
first middle last

Home Address _____ Home Phone _____

City_____ Work Phone _____

State _____Zip Code_____ Cell Phone_____

Age _____ Birthday _____ Social Security # _____ Female/Male Please

E-mail Address _____

If patient is a minor, give parent's or guardian's name _____

How did you hear about our office? _____

Whom may we thank for referring you to our office? _____

Does the patient have or has he/she ever had any of the following conditions?

MEDICAL HISTORY

YES	NO		YES	NO	
_____	_____	Thyroid Disease	_____	_____	AIDS or HIV Positive
_____	_____	Heart Disease	_____	_____	Chemical Dependency
_____	_____	High Blood Pressure	_____	_____	Surgery
_____	_____	Stroke	_____	_____	Hepatitis/Liver Disease
_____	_____	Cardiac Pacemaker	_____	_____	Kidney Disease
_____	_____	Lung Disease	_____	_____	Diabetes
_____	_____	Asthma	_____	_____	Epilepsy
_____	_____	Tuberculosis	_____	_____	Nervous Disorder
_____	_____	Rheumatic Fever	_____	_____	Tumor, Cancer
_____	_____	Heart Murmur/Mitral Valve Prolapse	_____	_____	Artificial Joints (Hips/Knees)
_____	_____	Prolonged Bleeding When Cut	_____	_____	Tobacco Use

Are you taking any medications (including herbal medications)? ☐ Yes ☐ No

If so, please list the medications: _____

_____

Are you allergic to any medication? ☐ Yes ☐ No

If so, please list: _____

Do you have any other diseases or conditions? ☐ Yes ☐ No

If so, please list? _____

Have you recently been under the care of a physician? ☐ Yes ☐ No

For what reason? _____

_____

Have you recently fainted or had difficulties in a dental office? (If yes, please explain) _____

_____

Is there any other health information that should be known? _____

_____

_____

Last dental care: Date _____

Name of dentist _____

Address _____

Has any member of your family received dental treatment in this office before? Names _____

_____

Name of family physician: _____

DENTAL HISTORY

	YES	NO
Have you ever experienced a problem with local anesthesia?	☐	☐
Do you have pain/clicking when opening or closing your jaw?	☐	☐
Have you ever had TMJ treatment?	☐	☐
Do you have any discomfort in your mouth presently?	☐	☐
Are your teeth sensitive to heat? Cold? Sweets?	☐	☐

If yes, please indicate which:_____

	YES	NO
Have you ever had your teeth straightened?	☐	☐
How often do you brush your teeth?	_____	
How often do you use dental floss?	_____	
Have you ever been diagnosed as having periodontal disease?	☐	☐
Do you grind or clench your teeth?	☐	☐
Are you aware of any swelling or lump in your mouth?	☐	☐
Do your gums bleed when you brush your teeth?	☐	☐
Do you get frequent blisters on the lips or mouth?	☐	☐

RESPONSIBLE PARTY INFORMATION

Name _____ (last / first / middle initial / marital status)

Address _____ (street / city / state / zip)

How long at this address _____ Home Phone _____

Previous Address (If less than 3 Yrs.) _____ (street / city / state / zip)

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ yrs. Employed _____

Employer's Address _____ Work Phone _____

Spouse's Name _____ (last / first / middle initial) Home Phone _____ Spouse's S.S. # _____

Spouse's Employer _____ Work Phone _____

Employer Address _____ Spouse's Birthday _____

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Do you have dual coverage? ☐ Yes ☐ No If yes:

SECONDARY CARRIER

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Insured's Employer _____

METHOD OF PAYMENT

_____ Cash _____ Check _____ MC/VISA

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

The information given about my health history in this form is accurate to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests (including X-rays) and evaluation of my dental health. I also authorize Dr. Purtell to perform any and all forms of treatment, medication and therapy that may be indicated.

Signature of patient, parent or guardian _____ Date _____

Medical review: I have reviewed this medical history and have added any changes since my last visit.

Updates (date and initial) _____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____