DENTAL REGISTRATION
(please print)

CHRIS A. CASTELLANO D.M.D. P.A.
6917 US Hwy 301 South · Riverview, FL 33578

Date:_____

PATIENT INFORMATON

Last Name:_____First Name:_____Initial:_____
Address_____
City:_____State:_____Zip code:_____
Sex: M___ F___ Age:____ Birthday: 00/00/00_____ Single___ Married___Widowed___ Divorced___
Home Phone:_____Cell Phone_____ Email _____
Patient employed by:_____Occupation:_____Soc#_____
Emergency contact name:_____Relation:_____Phone(___)_____

PRIMARY INSURANCE

Patient Work Phone (___)_____

Person insured last name:_____first name_____initial_____
Relation to patient_____Birthday:00/00/00_____Soc #_____-____-_____
Address if different from patient _____
City_____State:_____Zip code:_____
Person insured employed by:_____Occupation:_____
Business Address_____Business Phone(___)_____
Insurance Company_____Phone:(___)_____
Plan name_____Group #_____Other_____
List names of dependents covered under this plan: (last name, first)

_____
_____

SECONDARY INSURANCE

Person insured last name:_____first name_____initial_____
Relation to patient_____Birthday:00/00/00_____Soc #_____-____-_____
Address if different from patient _____
City_____State:_____Zip code:_____
Person insured employed by:_____Occupation:_____
Business Address_____Business Phone(___)_____
Insurance Company_____Phone:(___)_____
Plan name_____Group #_____Other_____
List names of dependents covered under this plan: (last name, first)

_____
_____

(OVER)

CHRIS A. CASTELLANO D.M.D. P.A.

DENTAL HEALTH HISTORY
(Confidential)

6917 US Hwy 301 South · Riverview, FL 33578

Today's Date_____

Patient Name_____ Birthdate_____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit_____

Former Dentist_____

Address_____

Date of last dental care_____ Date of last dental X-rays_____

Check (✓) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____ Phone:_____ Date of last visit_____

Address:_____ City_____ State_____ Zip_____

Have you had any serious illnesses or operations?_____ If yes, describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____