Matthew Balasco, D.D.S. Inc.
Practice Limited to Endodontics

PATIENT REGISTRATION

Matthew B. Balasco, D.D.S., M.S.

PLEASE PRINT AND FILL OUT THIS FORM COMPLETELY. THE BETTER WE COMMUNICATE, THE BETTER WE CAN CARE FOR YOU.

Patient's Name _____ Date _____

Parent / Guardian (if applicable) _____

Address _____

City _____ Zip _____ Phone _____

Marital Status _____ Date of Birth (Month, Day, Year) _____ Age _____

Patient's Social Security No. _____

Patient's Employer _____

Business Phone _____ Cell Phone _____

Contact Person in Case of Emergency _____

Relationship _____ Phone _____

Patient's Referring Dentist _____

DENTAL INSURANCE INFORMATION

Insured's Name (only if different from above) _____

Insured's Employer _____ Phone _____

Insurance Company _____ Group No. _____

Address _____ Ins. Phone _____

Insured's S.S. No. _____ Insured's Birth Date _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. IN ADDITION, I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

➜ _____ _____
Signed (Insured Person) Date

I UNDERSTAND THAT THE PERMANENT (OUTSIDE) RESTORATION (FILLING, CROWN, ETC.) IS TO BE COMPLETED BY MY GENERAL DENTIST. IT IS MY RESPONSIBILITY UPON COMPLETION OF THE ENDODONTIC TREATMENT TO CONTACT MY DENTIST (WITHIN 1-3 WEEKS) AND SCHEDULE AN APPOINTMENT.

➜ _____ _____
Signature Date

Acknowledgement of Receipt of Privacy Practices
I have received and/or had an opportunity to review a copy of Dr. Matthew B. Balasco's Notice of Privacy Practices

➜ _____ _____
Signature Date

PLEASE CONTINUE ON OTHER SIDE

HEALTH HISTORY

Physician _____ Phone _____

1. Are you now or have you in the past 5 years been under medical treatment? Yes No
2. Have you been hospitalized in the last 5 years? Yes No
3. Are you taking any drugs or medications?
   This includes prescribed, over-the-counter, and/or recreational. Yes No

   If yes, please list _____

   _____
4. Have you ever had an allergic reaction to any medications or materials?

   Antibiotics (eg. penicillin, sulfa, ampicillin) Yes No

   Pain medications (eg. codeine, aspirin, ibuprofen) Yes No

   Local anesthetics (eg. xylocaine, novacaine, other caines) Yes No

   Other (eg. foods, metals, latex, materials, ragweed) Yes No
5. Have you ever had hives or a rash? Yes No
6. Have you ever had any unusual effects from previous dental treatments? Yes No
7. Do you have a history of any excessive bleeding or blood disorders? Yes No
8. Do you have or have you ever had any of the following conditions? (please circle)

heart trouble	hearing impairment	stroke
heart murmur	asthma / emphysema	epilepsy / convulsions
mitral valve prolapse	respiratory problems	seizures / fainting
rheumatic fever	tuberculosis	diabetes
heart valve damage	persistent cough	AIDS or HIV positive
high blood pressure	sinus	hepatitis / jaundice
arthritis	abdominal distress	kidney / liver trouble
muscle / joint disease	ulcers	tumor / cancer
joint replacements	gastric reflux disorder	radiation therapy
osteoporosis		psychiatric treatment

9. Any medical problems or major surgeries not listed? Yes No
10. If any of the above questions were answered positively, please write question numbers(s) and a brief description.

    _____

    _____

    _____

    _____

WOMEN ONLY

11. Are you pregnant? (Weeks _____) Are you nursing? Yes No
12. Are you taking oral or subcutaneous contraceptives (birth control) Yes No

Note: Antibiotics and anticonvulsants may render contraceptives ineffective

The above information is complete and correct to the best of my knowledge.

➜ _____ _____

Signature Date