

Christopher Pescatore, D.M.D.

Aesthetic Dentistry

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____ E-mail: _____
Phone (Home): _____ (Work): _____ Ext: _____
Preferred appointment times: Morning Afternoon Any Time M T W Th
Address: _____
Street Apartment #
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? Another patient Radio
 Diablo magazine InStyle Magazine ALIVE Magazine Cosmopolitan magazine
 Marie Claire magazine Fitness magazine Plastic Surgeon _____ General Dental Office
 Other _____ Name of person or office referring you to our practice: _____

Aesthetic Evaluation

If you could change anything about your smile, what would it be?

- Whiter teeth
- More youthful / younger smile
- Broader / wider smile
- Straighter teeth
- More natural smile
- Other _____

What do you dislike about your old fillings?

- Unnatural color
- Sensitivity
- Other _____

Have you in the past ever been dissatisfied with another doctor or dentist? Yes No

If yes, please explain: _____

Additional comments or concerns _____

Due to Dr. Pescatore's expertise in this field, he is frequently asked to lecture to other dentists and author articles. By signing below, you give Dr. Pescatore permission to use your photographs and study models for teaching purposes.

Signature / Date

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

• Name of General Dentist: _____ Phone: _____
Address _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | Due date: _____ | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Phen Phen/ diet |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | supplements |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors | |

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years?

Yes No If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Are you currently taking any medication? Yes No

If yes, please explain: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian

Responsible Party Information

The following is for: the patient the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____

Insurance Information

Primary Insurance Company: _____
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____
Phone number _____
Secondary Insurance Company: _____
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____
Phone number _____