



Eugene A. Sambataro, D.D.S.,
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R E G I S T R A T I O N
Getting To Know Each Other

Welcome To Our Family Of Patients:



Thank you for choosing our office for your dental needs. We are proud that you have chosen us to be a partner in your family's dental health.

As a dentist of 26 years, I have always believed that I don't heal my patients, I am the facilitator as my patients take responsibility in their own healing process. This is where the partnership begins.

What makes our office different from most dental offices is our ability to integrate whole body health with the best that dentistry has to offer. With the latest in technology and the most up to date training, you will always receive treatment you can trust. Here we focus on the overall health and individuality of each of our patients. We take our diagnosis of a patients dental needs a step further than most dental offices, because we treat the *cause of*

the problem and not simply the *most current symptoms*. For example, going beyond recognizing what has brought about a cavity, with the obvious of sugar in the diet, we are able to see that this is a systemic problem that is related to the pH of a patients saliva, the state of their immune system or their genetic predisposition, as well as a host of other potential causes.

As a new member of our family of patients, you'll discover what others have, that we care about your well being and will work together to make the best decisions about you and your family's oral health.

As we move forward in this partnership, we make the promise that **your** needs will come first at each and every visit.

Dr. Gene Sambataro

Our Mission and Goals

We have a clear mission. One that we believe encompasses the essence of who we are and what we hope to achieve with each and every patient.

Our mission is:

"To increase the overall well being of health conscious individuals, through education, and the delivery of gentle non-toxic dental services in a facility designed for maximum comfort, by a team of gifted, compassionate and enlightened professionals."

In order for us to achieve our mission, we realize it is going to take hard work and dedication, as well as a few very clear goals.

Our goals are:

1. Provide our patients with a blend of dental techniques.
2. Provide ongoing education to our patients on the links between whole body wellness and oral health.
3. Take the time to listen to our patients needs and desires.
4. Provide our team with the most current training and specialization skills available in the industry
5. Provide treatment with the most state of the art equipment and technology
6. Employ the best team available to provide patients with the best patient service.
7. Always focus on what we can do to support our patients in their treatment decisions.

Tell Us About Yourself

A firm foundation is needed upon which to base recommendations for your dental health. Therefore, we ask that you complete both sides of this Registration & Health History form. The information you provide will insure safe dental treatment, aid us in diagnosis and treatment planning as well as help identify any precautionary measures we may need to take to protect your health. The information you provide is **STRICTLY CONFIDENTIAL**.

Patient's Name:		Date of Birth:	
Email Address:			
If Minor or Dependent, Parent's or Guardian's Name:		Relationship to patient:	
Street Address:	City :	State:	ZIP:
Occupation:		Place of Employment:	
Home phone:	Business phone:	Cell phone/Pager:	
Social Security #		Driver's Lic. #	
Marital Status:		Name of Spouse:	
Number of Children (or Siblings):			
Names/Ages			
Do you have dental insurance?		Insurance company:	
Policy Holder:		Policy holder's Social Security #	
Policy Holder's Employer:		Policy Holder's Date of Birth: _____	

Payment in full is expected at time of service, unless other arrangements have been made. For your convenience we accept cash, personal checks & credit cards. A deposit will be required to hold the time and date of your appointment. This will be credited toward your treatment. This deposit is non-refundable, if you need to reschedule your appointment, we would appreciate a minimum of 48 hours notice.

Your time is important to us. We do not run our office like a clinic with ten or more patients stacked up in the waiting room. The time we schedule for you is yours alone to receive the individual attention and quality care you deserve. So if you cancel or fail to show for your appointment, three people are hurt:

1. You, because you're not getting the care you need,
2. Another patient waiting for an appointment who is being prevented from receiving treatment,
3. The doctor and staff because we're not being productive and as helpful as we need and want to be. So, please be on time and keep your appointments.

There will be a minimum charge of \$125 for canceling an appointment with less than 48 hours notice.

In case of emergency please contact (closest relative or friend):

Address	Phone
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Whom may we thank for referring you to our office?

I understand that I am responsible for all costs of dental treatment. *I authorize the release of any information relating to this claim. I have read and agree to the terms stated above and that all information is true.

Signed (Patient, or parent if minor) (*For use if patient has dental insurance)

Date

Tell Us About Your Medical History

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

		Yes	No	N/A
1.	Are you under a physician's care currently?			
2.	Have you ever been hospitalized or had a major operation?			
3.	Have you ever had a serious head or neck injury?			
4.	Are you taking any medications, pills, or drugs?			
	Please List:			
5.	Do you take, or have you ever taken Phen-Fen or Redux?			
6.	Are you on a special diet?			
7.	Do you use tobacco?			
8.	Do you use controlled substances?			

Women: Are you:

- Pregnant/Trying to get pregnant:
 Nursing
 Taking oral contraceptives

Are you allergic to any of the following:

- Aspirin
 Penicillin
 Codeine
 Acrylic
 Metal
 Latex
 Local Anesthetics
 _____ (Please Explain Below)
- Other _____

Please check those that are a part of your current or past history:: Please indicate: (C=Current; P=Past)

AIDS/HIV Positive	Congenital Heart Disorder	Frequent Infections	Leukemia	Sickle Cell Disease
Alzheimer's Disease	Constipation	Genital Herpes	Liver Disease	Sinus Trouble
Anaphylaxis	Convulsions	Glaucoma	Low Blood Pressure	Sleep Apnea
Anemia	Cortisone Medicine	Hay Fever	Lung Disease	Snoring
Angina	Chronic Fatigue	Heart Attack/Failure	Lupus	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur*	Lyme Disease	Stomach/Intestinal Disease
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	*Mitral Valve Prolapse	Stroke
Artificial Joint*	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joints	Swelling of Limbs/Joints
Asthma	Emphysema	Hemophilia (or other bleeding disorder)	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Psycho Emotional Therapy	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss/Gain	Tumors or Growths
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Fibromyalgia	Hives or Rash	Rheumatic Fever*	Venereal Disease
Chemotherapy	Frequent Cough/Colds	Hypoglycemia	Rheumatism	Yellow Jaundice
Chest Pains	Frequent Diarrhea	Irregular Heartbeat	Scarlet Fever	
Cold Sores/Fever Blisters	Frequent Headaches	Kidney Problems	Shingles	OTHER: _____

Have you ever had any serious illness not listed above?
 Yes
 No
 N/A

*Condition may require medication.

N/A: Not answered by patient

Tell Us About Your Dental Health History

1.	Date of last exam:	
2.	Type of service rendered:	
3.	What concerns you most?	
4.	Have you ever had treatment for your gums, orthodontic treatment, root canal therapy or extractions?	If so, please describe:
5.	Have you ever had Novocain?	
6.	When was the last complete series of dental X-rays taken?	
7.	Are your teeth sensitive to hot, cold or sweets?	
8.	Do any teeth hurt when you chew?	
9.	Are you aware of any bad odor or taste in your mouth?	
10.	Do your gums bleed?	
11.	Do you grind or clench your teeth during the day or night?	
12.	Have you ever had pain, stiffness, or clicking in your jaw?	
13.	Do you have pain in or near your ears?	
14.	Have your teeth drifted or moved from their normal position?	
15.	Do you get cold sores or fever blisters?	How often?
16.	Have you experienced any growths or unhealed injuries?	
17.	Does food catch between your teeth?	If so, where?
18.	Are you satisfied with the appearance of your teeth?	
19.	Do you want to keep your own teeth as long as possible?	
20.	Do you chew on only one side of your mouth?	If so, why?
21.	Do you have all of your teeth?	If not, why?
22.	Were you told why missing teeth should be replaced?	
23.	How often do you brush? Do you floss?	Have you even been given instructions on the proper method of brushing?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian

Date