PELLEGRINI DENTAL

Date _____ **PATIENT REGISTRATION AND MEDICAL HISTORY**

(PLEASE PRINT LEGIBLY. FAX, MAIL, OR HAND DELIVER TO OUR FRONT DESK STAFF PRIOR TO YOUR APPOINTMENT)

Patient _____
Last Name First Name Initial Preferred Name

Mailing Address_____City_____State_____Zip_____

Preferred Phone_____ Other Phone_____ Email_____

Sex: □ M □ F Age_____ Birthdate_____ □ Student □ Single □ Married □ Widowed □ Separated □ Divorced

Employed by _____Occupation_____

Business Address_____Business Phone_____

Who is responsible for this account?_____ Social Security #_____

Spouse Name_____Spouse's Social Security #_____

Spouse Employed by _____Occupation_____

Business Address_____Business Phone_____

Primary Dental Insurance Company_____Group #_____ID#_____

Group Name _____Insured's Name:_____ DOB_____

Secondary Dental Insurance Company_____Group #_____ID#_____

Group Name _____Insured's Name:_____ DOB_____

In case of emergency, who should be notified?_____ Relationship_____ Phone_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name_____Date of Last Physical_____Preferred Pharmacy_____

Have you EVER had any of the following? Please mark **YES** or **NO** in response to **EACH** condition:

Y N	**Y N**	**Y N**
□ □ Heart disease/heart attack/A-fib	□ □ Diabetes or abnormal blood sugar	□ □ Cancer/growth/tumor
□ □ Heart murmur/rheumatic fever	□ □ Joint replacement	□ □ Radiation treatment/Chemotherapy
□ □ Heart surgery/valve replacement	□ □ Crohn's disease/colitis/bowel disorder	□ □ Recent unexpected weight change
□ □ High or abnormal blood pressure	□ □ HIV/AIDS	□ □ Chemical or drug dependency
□ □ Circulatory problem	□ □ Sexually transmitted disease	□ □ Alcoholism
□ □ Elevated cholesterol	□ □ Psychiatric care	□ □ Glaucoma/Serious eye disorder
□ □ Anemia/hemophilia/bleeding disorder	□ □ Anxiety	□ □ Kidney disease
□ □ Stroke/aneurysm	□ □ Depression	□ □ Liver disease/hepatitis/ jaundice
□ □ Asthma/emphysema	□ □ Arthritis	□ □ Suppressed immune system
□ □ Respiratory or lung disease	□ □ Back, neck or spinal problem	□ □ Thyroid disorder
□ □ Sinus problems	□ □ Frequent headaches	□ □ Tuberculosis
□ □ Ulcer or gastric reflux	□ □ Seizure or epilepsy	□ □ Gout

□ □ Have you ever had abnormal bleeding following a cut or dental extraction?
□ □ Do your ankles swell during the day?
□ □ Do you ever get pain in your chest or over your heart?
□ □ Do you get short of breath walking up the stairs of doing routine activities?
□ □ Do you use tobacco products (smoking or chewing)?
□ □ Are you allergic to latex?

Please list any other conditions, diseases, etc., not listed above that you feel are significant _____

_____

Please list any drugs or medications to which you have ever had an ALLERGIC or adverse reaction _____

_____

Please list all medications you are currently taking. Use a separate sheet of paper if necessary._____

_____

Please list all herbs or supplements you are taking at this time_____

_____

(Women only- Check box if appropriate.)

□ Do you suspect you are pregnant? □ Are you nursing? □ Are you taking birth control pills? □ Are you taking hormones?

DENTAL HISTORY

What is the reason for your dental visit today? _____

Y N

□ □ Have you ever had any serious problem associated with previous dental treatment?
□ □ Do your gums bleed when you brush or floss?
□ □ Does food catch between your teeth?
□ □ Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose?
□ □ Are any of your teeth sensitive to hot, cold or sweets?
□ □ Do you grind your teeth or clench your jaw?
□ □ Are there any sores or growths in your mouth?
□ □ Do any of your teeth ache?
□ □ Do you experience anxiety related to dental treatment?

□ □ Do you have any other dental complaint? _____

The information on this form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of the insurance benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize Pellegrini Family Dentistry, LLC to release any information including the diagnosis, records of treatment and examination, for myself and my dependent(s) to third-party insurance carriers, payers, and/or health practitioners. I authorize my insurance carrier to submit payment directly to Pellegrini Family Dentistry, LLC, and for the payment to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and that I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

_____ _____

Signature of patient, parent or guardian: Date:

_____

Relationship to patient: