



# Patient Registration Form

Date \_\_\_\_\_  
 SS# \_\_\_\_\_  
 Patient \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Single  Married  Divorced  Widowed  Separated  
 Spouse's Name \_\_\_\_\_  
 Spouse's Birthdate \_\_\_\_\_ Spouse's SS# \_\_\_\_\_  
 Spouse's Occupation \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 Employer Phone \_\_\_\_\_

**Insurance Information**  
 Who is responsible for this account? \_\_\_\_\_  
 Relationship to patient (if minor) \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Is the patient covered by additional insurance?  Yes  No  
 Subscriber's name \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
 Relationship to Patient (if minor) \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_

## Contact Information

Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile/Other \_\_\_\_\_  
 Best time and place to reach you \_\_\_\_\_ E-mail \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## Consent

**\*Signature needed below**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Pellegrino all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentists use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to persons who are involved in my care (or my child's care) or payment for that care.

Responsible Party Signature \_\_\_\_\_

Relationship to Patient (if minor) \_\_\_\_\_

Date \_\_\_\_\_

# Medications

List any medications you are currently taking:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Physician's Name \_\_\_\_\_  
 Date of last visit \_\_\_\_\_

# Drug Allergies

- Aspirin  Local Anesthetic  
 Barbiturates (sedatives/sleeping pills)  Penicillin  
 Codeine  Latex  
 Iodine  Other \_\_\_\_\_

# Dental History/Chief Complaint

Reason for today's visit \_\_\_\_\_  
 \_\_\_\_\_  
 Former Dentist \_\_\_\_\_  
 City/State \_\_\_\_\_  
 Date of last dental visit \_\_\_\_\_  
 Date of last dental x-rays \_\_\_\_\_

Please check any of the following you have experienced:  
 Bad breath  
 Bleeding gums  
 Blisters on lips or mouth  
 Burning sensation on tongue  
 Cigarette, pipe, cigar smoking  
 Clicking or popping jaw  
 Dry mouth  
 Fingernail biting  
 Grinding teeth  
 Gums swollen or tender

Jaw pain or tiredness  
 Lip or cheek biting  
 Loose teeth  
 Broken fillings  
 Mouth breathing  
 Mouth pain when brushing  
 Orthodontic treatment  
 Periodontal treatment  
 Sensitivity to hot or cold  
 Sensitivity to sweets  
 Sensitivity when biting  
 Sores or growths in your mouth

# Health History

**\*Signature needed below**

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine).  Yes  No

Have you taken any bisphosphonate drugs (includes Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Zometa)?  Yes  No

Has your physician ever recommended that you take antibiotics prior to dental appointments?  Yes  No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

**AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	**Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back/Neck Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding abnormally	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
**Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone/Steroid Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Disorders/Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
**Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hip, knee, or other joint replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Women:</b>								
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Due date _____			Are you nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking birth control pills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No						

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

