Patient Registration Form

Date_____

SS#_____

Patient_____

Preferred Name_____

Address_____

_____

Sex: ☐M ☐F Birthdate_____

Marital Status_____

Occupation_____

Employer_____

Spouse's Name_____

Insurance Information

Who is responsible for this account?_____

Insurance Co._____

Group #_____

Is the patient covered by additional insurance? _____

Subscriber's name_____

Birthdate _____SS#_____

Relationship to Patient _____

Insurance Co._____

Group #_____

How did you hear about our office?

_____

Contact Information

Mobile_____ Home_____ Work/Other_____

Best way to reach you_____ E-mail_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Mobile _____ Home _____ Work/Other_____

Consent *Signature needed below

I, the undersigned certify that I (or my dependent) have insurance coverage 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. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

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.

Signature (patient or responsible party) **Date**

Relationship to patient _____

Pellegrino
Cosmetic and Family Dentistry

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

Medications

List any medications you are currently taking:

Physician's Name_____

Date of last visit_____

Drug Allergies

Please check all that apply:

- ☐ **Aspirin**
- ☐ **Barbiturates (sedatives/sleeping pills)**
- ☐ **Codeine**
- ☐ **Iodine**
- ☐ **Local Anesthetic**
- ☐ **Penicillin**
- ☐ **Latex**
- ☐ **Other**_____

Health History *Signature needed below

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
IF YES, WHAT IS THE CONDITION THAT REQUIRES YOU TO TAKE ANTIBIOTICS? _____

WERE YOU HOSPITALIZED IN THE LAST 2 YEARS? ☐ Yes ☐ No IF YES, FOR WHAT REASON? _____

PLEASE REVIEW CONDITIONS BELOW AND CHECK ALL THAT APPLY:

**AIDS/HIV	☐ Yes	Fainting or dizziness	☐ Yes	Respiratory Disease	☐ Yes
Anemia	☐ Yes	Glaucoma	☐ Yes	Rheumatic Fever	☐ Yes
Arthritis, Rheumatism	☐ Yes	Headaches	☐ Yes	Scarlet Fever	☐ Yes
Artificial Heart Valves	☐ Yes	Heart Murmur	☐ Yes	Shortness of Breath	☐ Yes
Asthma	☐ Yes	**Heart Problems	☐ Yes	Sinus Trouble	☐ Yes
Back/Neck Problems	☐ Yes	Heart Attack/Heart Failure	☐ Yes	Skin Rash	☐ Yes
Bleeding abnormally	☐ Yes	Hepatitis Type ____	☐ Yes	Smoking	☐ Yes
Blood Disease	☐ Yes	Genital Herpes	☐ Yes	Stroke	☐ Yes
**Cancer	☐ Yes	High Blood Pressure	☐ Yes	Swollen Feet or Ankles	☐ Yes
Chemical Dependency	☐ Yes	Jaundice	☐ Yes	Swollen Neck Glands	☐ Yes
Chemotherapy	☐ Yes	Jaw Pain	☐ Yes	Thyroid Problems	☐ Yes
Circulatory Problems	☐ Yes	Kidney Disease	☐ Yes	Tonsillitis	☐ Yes
Congenital Heart Lesions	☐ Yes	Liver Disease	☐ Yes	Tuberculosis	☐ Yes
Cortisone/Steroid Treatments	☐ Yes	Low Blood Pressure	☐ Yes	Tumor or growth	☐ Yes
Cough, persistent or bloody	☐ Yes	Mitral Valve Prolapse	☐ Yes	Ulcer	☐ Yes
**Diabetes Type ____	☐ Yes	Nervous Disorders/Anxiety	☐ Yes	Sexually Transmitted Disease	☐ Yes
Emphysema	☐ Yes	Pacemaker	☐ Yes	Weight Loss, unexplained	☐ Yes
Epilepsy/Seizures	☐ Yes	Psychiatric Care	☐ Yes	**Joint Replacement (hip, knee, other)	☐ Yes
Cold Sores/Oral Herpes	☐ Yes	Radiation Treatment	☐ Yes	Drug Addiction/Alcoholism	☐ Yes
Bacterial Endocarditis	☐ Yes	Breathing Problem	☐ Yes	Severe Allergic Reaction	☐ Yes

Women:

Are you pregnant?	☐ Yes	Due date_____		Are you nursing?	☐ Yes ☐ No
Are you taking birth control pills?	☐ Yes				

PLEASE LIST ANY SERIOUS CONDITIONS NOT LISTED ABOVE:

To the best of my knowledge, all the preceding answers are correct. If I have changes in my health status or if my medicines change, I shall inform the dentist at the next appointment.

Patient Signature_____ **Date**_____

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:
❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA (please check all that apply):
❑ Cell Phone Confirmation

❑ Text Message to my Cell Phone

❑ Home Phone Confirmation

❑ Email Confirmation

❑ Work Phone Confirmation

❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA(please check all that apply) :
❑ Cell Phone Voice Message

❑ Text Message to my Cell Phone

❑ Home Phone

❑ Email

❑ Work Phone

❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via (please check all that apply):
❑ Phone Message

❑ Text Message

❑ Email

❑ **Any of the Above**

❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____

Please ***print*** name Legal Representative / Guardian Relationship of Legal Representative / Guardian

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment

❑ I could not communicate with the patient

❑ The patient refused to sign

❑ The patient was unable to sign because

❑ Other (please describe)_____

Signature of Privacy Officer_____