

Dr. Trudi Massaro REGISTRATION FORM

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.:		
			Cell phone no: ()		()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.:		
					()		
Whom may we thank for referring you?							
Other family members seen here:							
Purpose of visit:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.:	
						()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No				Cell Phone: ()			
Occupation:	Employer:	Employer address:			Employer phone no.:		
					()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				NAME OF INSURANCE COMPANY:			
Subscriber's Name:							
Subscriber's Address:		Subscriber's SS No:		Date of Birth: / /	Group No:	Ins Co. Phone #:	
Patient's Relationship to Subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Subscriber's Employer:		Employer's Address:					
Employer's Phone No:							

Is patient a full time student?

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:
			()	()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Dr. Massaro's office or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____

Date: _____

Patient Medical History

Patient Name: _____ Today's Date: _____

Physician's Name: _____ **Physician's Phone No:** _____

Are you currently under the care of a physician? Yes/No

Nature of care: _____

Have you had any serious illness or hospitalization in the last 5 years?

If so, please explain? _____

Please List All Medications You Are Presently Taking, Including Herbal Supplements :

Are you allergic to or have you reacted adversely to any of the following? (Please Circle)

Penicillin	Latex	Acetone	Aspirin
Codeine	Xylocaine	Valium	Tetracycline
Iodine	Ibuprofen	Novocaine	Sulfa

Allergy to other drugs not listed? _____

Please Circle any of the following that apply to you:

Abnormal Blood Pressure	AIDS/HIV	Allergies
Anemia	Arthritis	Artificial Heart Valve
Artificial Joints	Asthma	Endocarditis
Cancer	Congenital Heart Lesion	Heart Disease
Diabetes	Drug Dependency	Heart Murmur(or mitral valve prolapse)
Epilepsy	Fainting	Kidney Disease
Handicap	Glaucoma	Venereal Disease
Hepatitis	Jaundice	Ulcers
Tuberculosis	Liver Disease	Stroke
Prolonged Bleeding	Prolonged Cough	Thyroid Disease
Radiation Therapy	Rheumatic Fever	Psychosis
Pulmonary Illness		

Do you take antacid? Yes/No - What? _____ **Do you take Tagamet? Yes/No**

Do you consume grapefruit juice or grapefruit extract? _____

Current Weight: _____

Are you on any IV Medications? _____

Have you taken, or are you currently taking any of the following?

Fosamax Aredia Zometa Actonel Boniva Didronel Skelid

Do you have any indwelling devices such as:

Port Defibrillator Colostomy Pacemaker Catheter

Do you have any disease, condition or problem not previously listed?

Do you snore? Yes No Do you smoke or chew tobacco? Yes No
Frequency? _____

Are you pregnant? Yes No What Month? _____

Are you nursing? Yes No Are you taking hormones? _____

Are you taking birth control pills? _____