Mark Longobardi, DMD
169 Valley Street
Willimantic, Ct 06226

Patient Registration

Date_____ Home Phone_____ Cell Phone_____ Work Phone_____

PATIENT INFORMATION

Name_____ Birthdate _____ Sex ☐ M ☐ F Age_____

Address_____City _____ State_____ Zip_____

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Partnered ☐ Minor Social Security Number_____

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone (_____) _____

Whom may we thank for referring you? _____ ☐ Family ☐ Friend ☐ Internet ☐ Yellow Pages ☐ Doctor ☐ Other

In case of emergency who should be notified? _____ Phone (_____) _____

I give permission to discuss my dental care with: ☐ my spouse/partner ☐ my family ☐ my children ☐ Other _____

PRIMARY INSURANCE

Person responsible for account_____

Relation to Patient_____ Birthdate_____ Social Security Number_____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address_____ Business Phone (_____) _____

Insurance Company_____

Contract # _____ Group # _____ Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (if different) _____ Phone (_____) _____

City _____ State _____ Zip _____ Social Security Number _____

Employer _____ Business Phone (_____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. LONGOBARDI 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 AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. DR. LONGOBARDI MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

Patient/Responsible Party Signature _____ Date _____

Printed Name Relationship

MEDICAL HISTORY

Physician's Name _____ Phone (_____) _____ Date Last Visit _____

Have you ever used a bisphosphonate medication? Common names are: Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you had any serious illnesses or operations? If yes, describe: _____

_____

(Women) Are you pregnant? ☐ Yes ☐ No ☐ Maybe Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Alcohol/drug Addiction	☐ Chemotherapy	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Sleep Apnea
☐ Anemia	☐ Circulatory Problems	☐ Heart Problems	☐ Pacemaker	☐ Stroke
☐ Arthritis	☐ Cortisone Tx	☐ Hemophilia	☐ Radiation Tx	☐ Thyroid Problem
☐ Artificial Heart Valve	☐ Cough, persistent	☐ Hepatitis	☐ Respiratory Disease	☐ Tobacco Habit
☐ Artificial Joints	☐ Cough up Blood	☐ High Blood Pressure	☐ Rheumatic Disease	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ HIV/Aids	☐ Scarlet Fever	☐ Venereal Disease
☐ Blood Disease	☐ Epilepsy	☐ Jaw Pain		
☐ Cancer	☐ Fainting	☐ Kidney Disease		
	☐ Glaucoma	☐ Liver Disease		

☐ **Other** _____

MEDICATIONS	ALLERGIES	
List medications you are currently taking:	☐ Aspirin	☐ Latex
_____	☐ Barbiturates	☐ Other _____
_____	☐ Codeine	_____
_____	☐ Local Anesthetic	_____
_____	☐ Penicillin	_____
_____	☐ Sulfa	_____
Pharmacy Name _____ Phone _____		

DENTAL HISTORY

Reason for Today's Visit: _____ Date of last Dental Visit _____

Former Dentist: _____ Date of Last Dental X-rays _____

Check (✓) if you have any of the following:

☐ Clicking or Popping Jaw ☐ Periodontal treatment ☐ Bad Breath ☐ Grinding Teeth ☐ Sensitivity to Hot ☐ Loose Teeth or Broken Fillings ☐ Bleeding Gums

☐ Sensitivity to Biting ☐ Sensitivity to Cold ☐ Food Collection Between Teeth ☐ Sensitivity to Sweets ☐ Sores or Growths in Mouth ☐ Denture Problems

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. Date _____ Signature _____

Date	Change/ Signature	Date	Change/Signature