GREGG A. LOMBARDO, DDS, PA
PRACTICE LIMITED TO ORAL AND MAXILLOFACIAL SURGERY

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

PLEASE CHECK PREFERRED PHONE# FOR CONTACT HOME ☐ CELL ☐ WORK ☐

REFERRED BY: _____ Internet Listing ☐ Angie's List ☐ Yellow Pages ☐

Former Patient ☐ Name _____

PATIENT: _____

Last Name First Name Initial

ADDRESS:(*Please List Street as well as P.O. Box) _____

Street City State Zip

EMAIL ADDRESS _____

GENDER ☐ Male ☐ Female AGE: _____ BIRTH DATE: _____/_____/_____

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced SOCIAL SECURITY # _____/_____/_____

Patient's Employer: _____ Phone: _____

Is Patient a College Student? YES NO If Yes, Where? _____ Full Time / Part Time

Spouse's Name: _____

Spouse's Phone: _____ Spouse's Employer: _____

IF PATIENT IS A CHILD OR RESPONSIBLE PARTY

MOTHER'S NAME: _____ SOCIAL SECURITY # _____/_____/_____

FATHER'S NAME: _____ SOCIAL SECURITY # _____/_____/_____

ADDRESS (If different from above) _____

PHONE (If different from above) _____

MOTHER'S EMPLOYER: _____ PHONE: _____

FATHER'S EMPLOYER: _____ PHONE: _____

INSURANCE INFORMATION

NAME OF DENTAL INSURANCE CO.: _____

ADDRESS TO MAIL CLAIMS: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

I.D. NUMBER: _____ SUBSCRIBER'S BIRTH DATE: _____/_____/_____

NAME OF SECONDARY DENTAL INSURANCE CO. _____

ADDRESS TO MAIL CLAIMS: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

I.D. NUMBER: _____ SUBSCRIBER'S BIRTH DATE: _____/_____/_____

NAME OF MEDICAL INSURANCE CO.: _____

ADDRESS TO MAIL CLAIMS: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

I.D. NUMBER: _____ SUBSCRIBER'S BIRTH DATE: _____/_____/_____

Are you a Medicare participant? Yes ☐ No ☐

Please complete reverse side of this form. Sign, date and return to receptionist upon completion

DATE OF LAST PHYSICAL: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Check all boxes that apply)

☐ Heart Problems	☐ Epilepsy	☐ Special Diet
☐ High Blood Pressure	☐ Migraine Headaches	☐ Swollen Neck Glands
☐ Low Blood Pressure	☐ Hepatitis, Jaundice or Liver Disease	☐ Rheumatic Fever
☐ Circulatory Problems	☐ Cancer	☐ Sinus Problems
☐ Nervous Problems	☐ Psychiatric Care	☐ Immune System Disorder
☐ Radiation Treatment	☐ Chronic Diarrhea	☐ Stroke
☐ Artificial Heart Valves or Joints	☐ Allergies to Anesthetics	☐ Ulcer
☐ Recent Weight Loss	☐ Allergies to Medicine or Drugs	☐ Venereal Disease
☐ Back Problems	☐ General Allergies	☐ Chemical Dependency
☐ Diabetes	☐ Blood Disease	☐ Hemophilia
☐ Respiratory Disease	☐ Arthritis	☐ Blood Transfusion When? _____
☐ Asthma	☐ Glaucoma	

DO YOU SMOKE OR USE TOBACCO? YES ☐ NO ☐ IF "YES" HOW MANY/MUCH PER DAY? ___

HOW LONG (#OF YEARS) ___

DO YOU DRINK ALCOHOL? YES ☐ NO ☐ IF "YES" HOW MANY DRINKS PER DAY? ___

HOW LONG (#OF YEARS) ___

DO YOU HAVE ANY DRUG ALLERGIES OR HAVE YOU EVER HAD AN ADVERSE REACTION TO ANY MEDICATION? IF SO WHAT? _____

HAVE YOU EVER RESPONDED ADVERSELY TO MEDICAL OR DENTAL TREATMENT? _____

PLEASE LIST MEDICATIONS CURRENTLY TAKING _____

_____

BLOOD THINNER: (INCLUDING ASPIRIN) ☐ YES ☐ NO

ARE YOU UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO ☐ PHYSICIAN'S NAME _____

FOR WHAT CONDITIONS? _____

(Women) DO YOU SUSPECT THAT YOU ARE PREGNANT ☐ YES ☐ NO ARE YOU NURSING? ☐ YES ☐ NO

ARE YOU CURRENTLY TAKING ANY FORM OF BIRTH CONTROL? ☐ YES ☐ NO

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY? _____

_____

IS TODAY'S VISIT DUE TO ACCIDENT? ☐ AUTO ☐ OTHER DATE OF ACCIDENT _____

REGARDLESS OF INSURANCE, CONSULTATION FEE WILL BE COLLECTED AT TODAY'S VISIT

METHOD OF PAYMENT TODAY: ☐ CASH ☐ CHECK ☐ VISA/MASTERCARD ☐ DISCOVER

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT. I AUTHORIZE TREATMENT BY **GREGG A. LOMBARDO, DDS. PA** AND RELEASE ANY AND ALL MEDICAL INFORMATION FOR THE PURPOSE OF INSURANCE AND/ OR MEDICAL BENEFITS PAYMENT. I HEREBY AUTHORIZE INSURANCE BENEFITS TO BE PAID DIRECTLY FOR MEDICAL OR SURGICAL TREATMENT TO **GREGG A. LOMBARDO, DDS. PA**

ACCOUNTS OVER 90 DAYS ACCRUE INTEREST AT THE RATE OF 1.5% PER MONTH OR UNTIL ACCOUNT IS PAID IN FULL. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED BY THIS OFFICE TO COLLECT MY ACCOUNT IN THE EVENT THAT I DEFAULT ON PAYMENT ARRANGEMENTS MADE WITH THIS OFFICE. THESE CHARGES INCLUDE, BUT ARE NOT LIMITED TO LEGAL, DOCUMENTATIONAL AND HANDLING FEES IN AN EFFORT TO COLLECT THIS ACCOUNT.

SIGNATURE _____ DATE _____