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

HOME PHONE: CELL PHONE	ONE: WORK PHONE:			
PLEASE CHECK PREFERRED PHONE# FOR CONTA	CT HOME \square CELL \square WORK \square			
REFERRED BY: Interr	et Listing Angie's List Yellow Pages			
Form	r Patient Name			
PATIENT:				
Last Name First Na	ne Initial			
ADDRESS:(*Please List Street as well as P.O. Box) Street	City State	 Zip		
EMAIL ADDRESS	City State	ΖΙΡ		
GENDER □ Male □ Female AGE:	BIRTH DATE:/_	/		
MARITAL STATUS: ☐ Married ☐ Single ☐ Divo	ced SOCIAL SECURITY #/	/		
Patient's Employer:	Phone:			
Is Patient a College Student? YES NO If Yes				
Spouse's Name:				
ouse's Phone: Spouse's Employer:				
IF PATIENT IS A CHI	D OR RESPONSIBLE PARTY			
MOTHER'S NAME:		/		
FATHER'S NAME:				
ADDRESS (If different from above)				
PHONE (If different from above)				
MOTHER'S EMPLOYER:				
		PHONE:		
	CE INFORMATION			
NAME OF DENTAL INSURANCE CO.:				
ADDRESS TO MAIL CLAIMS:				
SCRIBER'S NAME: RELATIONSHIP TO PATIENT:				
I.D. NUMBER:				
NAME OF SECONDARY DENTAL INSURANCE CO				
ADDRESS TO MAIL CLAIMS:				
		RELATIONSHIP TO PATIENT:		
	SUBSCRIBER'S BIRTH DATE://			
NAME OF MEDICAL INSURANCE CO.:				
ADDRESS TO MAIL CLAIMS:				
SUBSCRIBER'S NAME:				
I.D. NUMBER:	SUBSCRIBER'S BIRTH DATE:/	/		
Are you a Medicare participant? Yes □ No □				

DATE OF LAST PHYSICAL:			
HAVE YOU EVER HAD ANY OF THE	FOLLOWING? (Check all boxes that appl	у)	
☐ 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	\square 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 \square NO \square IF "YES" HOW MANY/MUCH PER DAY?			
HOW LONG (#OF YEARS)			
DO YOU DRINK ALCOHOL?	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) \square YES \square 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 \square YES \square NO ARE YOU NURSING? \square YES \square NO			
ARE YOU CURRENTLY TAKING ANY FORM OF BIRTH CONTROL? \square YES \square 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	DA	TE	