Nicholas Addiego, D.M.D., LLC
810A Barnegat Ave., Ship Bottom, NJ 08008
Phone: 609-361-2900 Fax: 609-361-2902

REGISTRATION AND PERSONAL HISTORY

Date:_____

Patient's Name: _____

Address: _____City:_____ State:_____ Zip:_____

By what name would you like to be addressed? _____ Sex: M_____ F _____

Home Phone:_____ Cell Phone: _____ Work Phone:_____

Date of Birth:_____ Soc. Sec #: _____

Patient's Occupation:_____ Patient's Employer: _____

Name of General Dentist: _____ Who referred you? _____

Have you ever been treated in any of our offices before? Y_____ N_____

If patient is over 18 years old and a full-time student:

Name of School: _____ City:_____

PRIMARY DENTAL INSURANCE

FILL OUT ONLY IF YOU HAVE DENTAL INSURANCE

Name of Insurance Co.

Address

City State Zip

ID/Agreement No.

Group Name or No.

FILL OUT REMAINDER ONLY IF DIFFERENT FROM PATIENT

In whose name is the insurance

Date of Birth Soc. Sec. #

Employer

Address

How is this person related to patient?

SECONDARY DENTAL INSURANCE

FILL OUT ONLY IF DIFFERENT FROM PATIENT

Name of Insurance Co.

Address

City State Zip

ID/Agreement No.

Group Name or No.

FILL OUT REMAINDER ONLY IF DIFFERENT FROM PATIENT

Name of Insured

Date of Birth Soc. Sec. #

Employer

Address

How is employee related to patient?

HEALTH HISTORY

1. General Health
   Excellent ☐ Good ☐ Fair ☐ Poor ☐
2. Are you under the care of a physician?
   Yes ☐ No ☐ Don't Understand ☐
   If so, please explain _____
3. Name of Family Physician _____
4. Are you taking any kind of medication (prescribed or non-prescribed) at this time?
   Yes ☐ No ☐ Don't Understand ☐
   If yes, please list _____
5. Have you been diagnosed as having AIDS or diagnosed as HIV positive? Yes ☐ No ☐
6. Are you pregnant? Yes ☐ No ☐ Months _____
7. Are you currently taking birth control pills?
   Yes ☐ No ☐
8. Are you allergic to any foods or medications?
   Yes ☐ No ☐ don't know ☐

Circle any of the following to which you are allergic or have had an unusual reaction?

Penicillin	Codeine
Sulfa Drugs	Valium (tranquilizers)
Erythromycin	Sedatives (Barbiturates)
Novacaine (Xylocaine)	Demerol
Motrin, Advil, Nuprin	Nitrous Oxide
Aspirin	Steroids
Darvon	Other _____

9. Have you ever been hospitalized or had surgery or anesthesia in the last five years? Yes ☐ No ☐
   If so, when? _____
   For what reason? _____
10. Have you ever been treated for substance abuse?
    Yes ☐ No ☐ Don't Understand ☐
11. Are you wearing a pacemaker or heart valve prosthesis?
    Yes ☐ No ☐
12. Do you have artificial joint replacement?
    Yes ☐ No ☐ Don't Understand ☐
13. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
    Yes ☐ No ☐ Don't Understand ☐
14. Have you ever undergone root canal treatment?
    Yes ☐ No ☐

Circle any of the following which you have ever had or have now

Heart Trouble	Tuberculosis
Heart Murmur	Epilepsy
Rheumatic Fever	Convulsions
High Blood Pressure	Glaucoma
Angina	Hyperthyroid
Stroke	Thyroid Trouble
Mitral Valve Prolapse	Fainting Spells
Congenital Heart Disease	Venereal Disease
Hepatitis	Herpes
Anemia	Arthritis
Sinus Trouble	Kidney Trouble
Asthma	Radiation Therapy
Hay Fever	Psychiatric Treatment
Diabetes	Blood Disorders
Migraines	Ulcers
Pacemaker	Lung Disease

Is there anything else about your health we should know?

_____

_____

_____
Patient Signature *(or guardian or parent)* **date**

_____
Dentist Signature **date**

DOCTOR'S USE ONLY

☐ PRE-MEDICATE

☐ MEDICAL ALERT

VITAL SIGNS	INITIAL AND DATE

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)

Doctor's Comments _____

_____

_____ *Signature* _____ *Date* _____