Gary C Mangieri, DMD, PLLC
GENERAL AND COSMETIC DENTISTRY

800 PERRY HIGHWAY, SUITE 2
PITTSBURGH, PENNSLVANIA 15229
PHONE (412) 366-0668
FAX (412) 366-5057
Email: mangieri800@gmail.com
www.mangieridental.com

REGISTRATION FORM

Last Name____________________ First____________________ Middle____________________

Home Address____

Home Phone____________________ Work____________________ Cell____________________

Email________________________ Best way to be contacted____________________________

DOB________________ Martial Status_________ SSN______________ Referred By____________________

PRIMARY INSURANCE COVERAGE

Subscriber's Name____

Subscriber's Address____

Relationship to Patient__________________ ID#________________________ DOB____________________

Employer's Name/Address____

Insurance Company Name/Address____

Group Name______________________ Group#______________________ Coverage Type________________

SECONDARY INSURANCE COVERAGE

Subscriber's Name____

Subscriber's Address____

Relationship to Patient__________________ ID#________________________ DOB____________________

Employer's Name/Address____

Insurance Company Name/Address____

Group Name______________________ Group#______________________ Coverage Type________________

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:	Today's Date:	Date of Last Visit:	Date of Med. History:

City State Zip:	Email:

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:

Primary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Secondary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
☐ ☐ Are you taking Birth Control Pills?
☐ ☐ Are you pregnant? If Yes, # of weeks
☐ ☐ Are you nursing?

Please answer the following:

Y N
☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y N	Conditions	Y N	Conditions	Y N	Conditions
☐ ☐	Bleeding Gums	☐ ☐	Mitral Valve Prolapse	☐ ☐	Alcohol Abuse
☐ ☐	Gums Swollen Or Tender	☐ ☐	Rheumatic Fever	☐ ☐	Drug Abuse
☐ ☐	Loose Teeth Or Broken Filling	☐ ☐	Pace Maker	☐ ☐	HIV+ AIDS
☐ ☐	Tooth Sensitivity To Cold	☐ ☐	Asthma	☐ ☐	Radiation Therapy
☐ ☐	Tooth Sensitivity To Hot	☐ ☐	Tuberculosis	☐ ☐	Cancer- Chemotherapy
☐ ☐	Tooth Sensitivty To Sweets	☐ ☐	Arthritis	☐ ☐	Venereal Disease
☐ ☐	Sensitivity To Biting	☐ ☐	Artifical Joints		
☐ ☐	Food Collection Between Teeth	☐ ☐	Diabetes		
☐ ☐	Mouth Ulcers/Fever Blisters	☐ ☐	Kidney Problems	Y N	Allergies
☐ ☐	Dry Mouth	☐ ☐	Thyroid Problems	☐ ☐	Aspirin
☐ ☐	Pain In Jaw Joints	☐ ☐	Glaucoma	☐ ☐	Codeine
☐ ☐	Grinding Teeth	☐ ☐	Hepatitis	☐ ☐	Dental Anesthetics
☐ ☐	Pain With 3rd Molars	☐ ☐	Stroke	☐ ☐	Erythromycin
☐ ☐	Orthodontic Treatment	☐ ☐	Epilepsy	☐ ☐	Jewelry
☐ ☐	Periodontal Treatment	☐ ☐	Seizures	☐ ☐	Latex
☐ ☐	Sinus Problems	☐ ☐	Frequent Headaches	☐ ☐	Metals
☐ ☐	Angina Pectoris	☐ ☐	Anemia	☐ ☐	Penicillin
☐ ☐	Difficulty Breathing	☐ ☐	Abnormal Bleeding	☐ ☐	Tetracycline
☐ ☐	Artificial Heart Valve	☐ ☐	Hemophilia		Other
☐ ☐	Congenital Heart Defect	☐ ☐	Sickle Cell Disease		
☐ ☐	Heart Attack	☐ ☐	High Blood Pressure		
☐ ☐	Heart Surgery	☐ ☐	Low Blood Pressure		

Medications:

Y N

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below..

Notes:

Signature: ______________________________ Date: ______________

(If Under 18, Parent or Guardian Signature Required)