# DR. LYNN PIERRI'S OFFICE - PATIENT REGISTRATION

Lynn Pierri DDS, MS
Caring Without Compromise™

400 Townline Road, Ste. 135
Hauppauge, NY 11788
P: (631) 360-0266 F: (631) 360-0087

**Please complete and return this form to the receptionist along with your medical & dental insurance cards and claim forms. Please ask the receptionist if you require assistance. Thank you for your cooperation**

**PLEASE PRINT CLEARLY**

**Today's Date:** **Email Address:**

**Title:** ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Dr.** **Gender:** ☐ **Male** ☐ **Female** **Height:** **Weight:** lbs.

**Name:** (Last) (First) (M.I,) **Prefer to be called:**

**Date of birth:** **Social Security#:** - - **DMV#:**

**Address:** (Street) (City) (State) (Zip)

**Home phone#:** **Cell phone#:** **Work phone#:**

**When is the best time to reach you?** ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Night**

**SPOUSE INFORMATION (Necessary if your spouse is the insured party)**

**Spouse Name:** **Social Security#:** - - **Date of birth:**

**EMPLOYER INFORMATION (Necessary for insurance purposes)**

**Employer name:**

**Address:** (Street) (City) (State) (Zip)

**EMERGENCY CONTACT INFORMATION (A friend or relative not living with you)**

**Name:** **Relation:**

**Home address:** (Street) (City) (State) (Zip)

**Home phone#:** **Cell phone#:** **Work phone#:**

**SIGNATURE ON FILE (Please read)**

* I declare: all information given on my health history is complete, correct, and answered to my satisfaction and permit use of electronic copies in place of the original.
* I understand the importance of a truthful health history to assist the doctor in providing the best care possible.
* I will not hold my dentist/doctor, or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

* I acknowledge, by signing any consents for surgery; I, or my legal guardian, fully understand all procedures and treatment plans proposed for my benefit.
* I acknowledge; I, or my legal guardian, have the right to ask questions about my procedure and financial responsibility prior to surgery.
* I authorize use of this form on all my insurance submissions and authorize release of information to all my insurance companies.
* I understand my patient rights & responsibilities as posted as well as advanced directives/healthcare proxy & right to change provider.
* I understand that I am financially responsible for any charges not covered by insurance including copays, co-insurance and deductibles.
* I understand I am financially responsible for all past, present and future balances on my account that are not covered by my insurance carriers.
* I agree, in the event I fail to timely make any payments due & this matter is sent to an attorney for collection, I will be responsible for any and all legal & collection fees.
* I understand, if I dispute my insurance carriers decision(s), I will pay what I owe until such time I can overturn the insurance carriers decision.
* I authorize Dr. Lynn Pierri to act as my agent in helping me obtain payment from my insurance company(s) and authorize payment directly to Lynn Pierri, DDS, MS.
* I fully understand that I am responsible for obtaining referrals to be seen in this office and will reschedule if I do not have a referral in time for my appointment.

* I have been informed about the procedures for expressing suggestions, complaints and grievances and will do so without expressing my opinions on social media.
* I understand that I will be given pre-op and postoperative instructions, if applicable, and will make every effort to read and understand those instructions.
* When prescribed medication, I will make every effort to understand the proper usage and dosage of those medications prior to use.
* If I ever have a change in my health, medication, medical/dental insurance or billing address; I will inform Dr. Lynn Pierri's staff on or before my next appointment.
* Although cone beam tomography and dental x-rays are offered within this office, I understand that I have the right to ask for alternative imaging facialities prior to testing.
* By providing my email address above I understand my email address will be kept private and agree to receive emails from Lynn Pierri DDS MS and associated entities.

**ATTESTATION**

I have read the "signature on file" section above and understand these responsibilities as the patient or legal guardian.

**I understand that preauthorization is not a guarantee of payment and I will be responsible for payment in full.**

**Patient (or guardian) signature:** **Date:**

**Please print your name:**

**Witness:** **Date:** **Doctor's init:**

**MEDICARE PATIENTS ONLY**: Dr. Pierri has advised me that services may not be considered by Medicare to be medically reasonable or necessary and may not be covered. Knowing this, I have instructed the doctor to proceed with the services. If Medicare decides to reduce or deny services, I agree to pay the doctor's limiting charge.

**Patient Signature:** **Witness:** **Date: / /** **Dr. Init:**

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Name: DOB:

## REFERRAL INFORMATION

**Whom may we thank for referring you?**

## PRIMARY CARE PHYSICIAN AND DENTIST INFORMATION (REQUIRED FOR MEDICARE PATIENTS)

**YOUR DENTIST'S NAME:** ☐ Previous ☐ Present ☐ None

**PHONE#:**

**YOUR DENTIST'S ADDRESS:**

Street City State Zip

**Last seen:** **Reason:**

**YOUR PHYSICIAN'S NAME:** ☐ Previous ☐ Present ☐ None

**PHONE#:**

**YOUR PHYSICIAN'S ADDRESS:**

Street City State Zip

**Last seen:** **Reason:**

## PRIMARY INSURANCE INFORMATION (Please bring insurance cards or proof of coverage with you)

**DO YOU HAVE MEDICAL COVERAGE?** ☐Yes ☐No

**PRIMARY MEDICAL**

**Name of insured:**
**Date of birth:**
**Social Security#** - -
**Relationship to patient:**
**Insured's employer:**
**Insurance company name:**
**Insurance ID#:**
**Group number:**
**Insurance address:**
**City:** State: Zip:
**Insurance phone#:**
**If Union, Local#:**

**DO YOU HAVE DENTAL BENEFITS?** ☐Yes ☐No

**PRIMARY DENTAL BENEFITS**

**Name of insured:**
**Date of birth:**
**Social Security#** - -
**Relationship to patient:**
**Insured's employer:**
**Insurance company name:**
**Insurance ID#:**
**Group number:**
**Insurance address:**
**City:** State: Zip:
**Insurance phone#:**
**If Union, Local#:**

## SECONDARY INSURANCE INFORMATION

**SECONDARY MEDICAL**

**Name of insured:**
**Date of birth:**
**Social Security#** - -
**Relationship to patient:**
**Insured's employer:**
**Insurance company name:**
**Insurance ID#:**
**Group number:**
**Insurance address:**
**City:** State: Zip:
**Insurance phone#:**
**If Union, Local#:**

**SECONDARY DENTAL BENEFITS**

**Name of insured:**
**Date of birth:**
**Social Security#** - -
**Relationship to patient:**
**Insured's employer:**
**Insurance company name:**
**Insurance ID#:**
**Group number:**
**Insurance address:**
**City:** State: Zip:
**Insurance phone#:**
**If Union, Local#:**

## BILLING PARTY

☐ Self ☐ Mother: Date of Birth: ☐ Father: Date of Birth:

I, the responsible party, understand that I am responsible for all referrals, copayments, co-insurance and deductibles as indicated by my insurance carriers. I am also responsible for all charges not covered by insurance.

**Patient Signature:** **Witness:** **Date:** **Doctor:**

Name: DOB:

**CHIEF COMPLAINT**

☐ Anesthesia Consult ☐ Burning Mouth ☐ Dental Implants ☐ Infection ☐ Soft Tissue ☐ Uncovering

☐ Apicoectomy ☐ Exposure ☐ Uprighting ☐ Periodontal ☐ Sleep Apnea ☐ Wisdom Teeth

☐ Biopsy ☐ Extraction ☐ Impacted Tooth ☐ Restorative ☐ TMJ ☐ Trauma ☐ Pre-prosthetic

☐ Frenectomy ☐ Implant Removal ☐ Salivary ☐ Tori/Epuli Removal ☐ Other:

Explain:

**HISTORY OF PRESENT ILLNESS (HPI)**

**Location:** ☐ Upper Right ☐ Lower Right ☐ Right TMJ ☐ Upper Left ☐ Lower Left ☐ Left TMJ
☐ Right Tongue ☐ Right Cheek ☐ Top Frenum ☐ Left Tongue ☐ Left Cheek ☐ Tongue-tie
☐ Palate (roof) ☐ Upper Lip ☐ Floor of mouth ☐ Lower Lip ☐ Other:

**Describe the pain you are feeling:** ☐ None ☐ Sharp ☐ Burning ☐ Irritation ☐ Aching
☐ Other: ☐ Dull ☐ Radiating ☐ Discomfort ☐ Soreness ☐ Throbbing

**On a scale from 1 to 10, (10 being the most severe), how would you rate your symptoms?**
☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

**When did these symptoms begin?** Days Weeks Months Years
☐ I don't remember ☐ Other:

**How often do you have symptoms?** ☐ Comes & Goes ☐ Frequently ☐ All the time
☐ Other:

**What triggered your symptoms?** ☐ Chewing ☐ Drinking ☐ Trauma
☐ Medications ☐ I don't know ☐ Other:

**What helps your symptoms feel better?** ☐ Warm liquids ☐ Cold liquids ☐ Salt water rinse
☐ Dry Heat ☐ Moist Heat ☐ Other:

**What other signs or symptoms are you experiencing?**
☐ Numbness ☐ Tingling ☐ Swelling ☐ Rash
☐ Bleeding ☐ Discharge ☐ Pain ☐ Other:

**PAST HISTORY - List major surgery(s) or hospitalization(s)**

| Surgery Type/Admission | Year | Doctor | Hospital | Anesthesia/Surgery Complications |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**PATIENT HISTORY OF SEDATION / GENERAL ANESTHESIA**

**Have you had anesthesia before?** ☐ No ☐ Yes, last date:

**Did you have any problems, reactions or issues?** ☐ No ☐ Yes, please explain:

☐ Nausea or Vomiting ☐ Prolonged wake up ☐ Other:

**Have you, as a result of anesthesia, ever suffered the following?**

☐ Pseudocholinesterase Deficiency ☐ Malignant Hyperthermia ☐ Nausea or Vomiting
☐ Unanticipated postoperative mechanical ventilation ☐ Unplanned/unanticipating hospital admission

**FAMILY HISTORY OF SEDATION / GENERAL ANESTHESIA**

**Has anyone in your family, as a result of anesthesia, ever suffered the following?**

☐ Pseudocholinesterase Deficiency ☐ Malignant Hyperthermia ☐ Nausea or Vomiting
☐ Unanticipated postoperative mechanical ventilation ☐ Unplanned/unanticipating hospital admission
☐ Other:

**Patient Signature:** **Witness:** **Date:** **Doctor:**

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Name: DOB:

## FAMILY HISTORY

| | Eye Problem /Blindness | Glaucoma | Cancer: Type: | Heart Disease/ Attack | Diabetes | Stroke | Alive/Deceased |
|---|---|---|---|---|---|---|---|
| Father | | | | | | | ☐ A ☐ D |
| Mother | | | | | | | ☐ A ☐ D |
| Siblings | | | | | | | ☐ A ☐ D |
| Other Family | | | | | | | ☐ A ☐ D |

**Have other family members suffered from the same Chief Complaint presented today?** ☐ Yes ☐ No

## SOCIAL HISTORY

**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**What is your occupation?** ☐ Full-time ☐ Part-time ☐ Retired ☐ Not working

**Do you smoke?** ☐ Yes ☐ No If yes, How many packs per day? How many years? ☐ Past smoker

**Do you chew tobacco?** ☐ Yes ☐ No If yes, How often? ☐ Daily ☐ Weekly ☐ Monthly

**Do you drink alcohol?** ☐ Yes ☐ No How frequent? ☐ Daily ☐ Weekly ☐ Monthly

**Recreational drugs?** ☐ Yes ☐ No If yes, type: How frequent? ☐ Daily ☐ Weekly ☐ Monthly

**WARNING: Combining Cocaine/Amphetamines and local anesthesia can lead to fatal arrhythmias**

**Sexual Diseases?** ☐ No ☐ Yes ☐ Syphilis ☐ Gonorrhea ☐ Chlamydia ☐ Scabies ☐ HPV ☐ Warts ☐ Other:

**Level of Education:** ☐ Grammar ☐ High School ☐ College ☐ Post-Grad

## RECENT TRAVEL

**Were you born in this country?** ☐ Yes ☐ No, Where:

**Have you traveled out of the country in the last 2 years?** ☐ No ☐ Yes, Traveled in:

**Have you been exposed to the Zika or Ebola viruses? If so, when?**

## ANTIBIOTIC PROPHYLAXIS INFORMATION

**Is an antibiotic prophylaxis required prior to surgery?** ☐ Yes ☐ No **Did you take it today?** ☐ Yes ☐ No

**Prophylaxis is taken for:** ☐ Heart Murmur ☐ Rheumatic Heart Disease/Fever ☐ History of Infective Endocarditis

☐ Artificial Heart Valve ☐ Artificial Joint ☐ Artificial Device ☐ Congenital Heart Defect Repair with Residual Defect

☐ Cyanotic Congenital Heart Disease (repaired or unrepaired) ☐ Congenital Heart Defect repaired with prosthetic material

☐ Cardiac transplant with heart valve problems

**Prophylaxis Regimen:** ☐ Amoxicillin ☐ Cleocin ☐ Other, explain:

## ADVANCED DIRECTIVES

**Have you selected someone to make decisions for you if you were not able?** ☐ Yes ☐ No

**If yes, please specify:**

**Do you have a:** Health Care Proxy ☐ Yes ☐ No Living Will ☐ Yes ☐ No

DNR ☐ Yes ☐ No Organ Donor ☐ Yes ☐ No

**If no, to any of the above, do you want additional information or assistance filling out an Advanced Directive?** ☐ Yes ☐ No

**If yes, have you provided this office a copy for your chart?** ☐ Yes ☐ No - Copy Requested: Date:

## DENTAL HISTORY

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ☐ Yes | ☐ No | TMJ | ☐ Yes | ☐ No | Wear Night Guard | ☐ Bad Dental Experience? | | |
| ☐ Yes | ☐ No | Orthodontic (braces) | ☐ Yes | ☐ No | Wear Ortho Retainer | ☐ Increased bleeding w/extraction? | | |
| ☐ Yes | ☐ No | Periodontal (gum) | ☐ Yes | ☐ No | Previous Dental Surgery | ☐ Questions for the doctor? | | |
| ☐ Yes | ☐ No | Endodontic (root canal) | ☐ Yes | ☐ No | Sleep/Snore Device | Explain: | | |

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Name: DOB:

**Do you, or have you, ever had any of the following?**

| Yes | Past | No | CONSTITUTIONAL |
|---|---|---|---|
| ☐ | ☐ | ☐ | Anorexia |
| ☐ | ☐ | ☐ | Breast Cancer |
| ☐ | ☐ | ☐ | Bulimia |
| ☐ | ☐ | ☐ | Chemotherapy for Cancer/Type: |
| ☐ | ☐ | ☐ | Methicillin Resistant Staph Aureus (MRSA) |
| ☐ | ☐ | ☐ | Radiation for Cancer/Type:Loca: |
| ☐ | ☐ | ☐ | Special diet |
| ☐ | ☐ | ☐ | Weight gain/loss |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | EYES |
|---|---|---|---|
| ☐ | ☐ | ☐ | Eyeglasses/contacts |
| ☐ | ☐ | ☐ | Glaucoma |
| ☐ | ☐ | ☐ | Loss of vision or blindness |
| ☐ | ☐ | ☐ | Macular Degeneration |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | EARS / NOSE / MOUTH / THROAT |
|---|---|---|---|
| ☐ | ☐ | ☐ | Burning Tongue |
| ☐ | ☐ | ☐ | Deafness |
| ☐ | ☐ | ☐ | Difficulty swallowing (Dysphagia) |
| ☐ | ☐ | ☐ | Nose Bleeds (Epistaxis) |
| ☐ | ☐ | ☐ | Radiation to Head/Neck |
| ☐ | ☐ | ☐ | Ringing in ears (Tinnitus) |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | SKIN |
|---|---|---|---|
| ☐ | ☐ | ☐ | Cancer: Basal Cell |
| ☐ | ☐ | ☐ | Cancer: Melanoma |
| ☐ | ☐ | ☐ | Cancer: Squamous Cell |
| ☐ | ☐ | ☐ | Psoriasis |
| ☐ | ☐ | ☐ | Rash, Sores, Ulcers |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | IMMUNITY |
|---|---|---|---|
| ☐ | ☐ | ☐ | Chronic Fatigue |
| ☐ | ☐ | ☐ | Immunocompromised/Immunodeficiency |
| ☐ | ☐ | ☐ | C-1 Esterase Deficiency |
| ☐ | ☐ | ☐ | Lupus |
| ☐ | ☐ | ☐ | Sjogrens |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | HEME / LYMPHATIC |
|---|---|---|---|
| ☐ | ☐ | ☐ | Anemia |
| ☐ | ☐ | ☐ | Leukemia / Lymphoma |
| ☐ | ☐ | ☐ | Sickle Cell |
| ☐ | ☐ | ☐ | Thallasemia (Cooley's Anemia) |
| ☐ | ☐ | ☐ | Hemophilia |
| ☐ | ☐ | ☐ | Von Willenbrands |
| ☐ | ☐ | ☐ | Platelet Disorder |
| ☐ | ☐ | ☐ | Clotting Factor Deficiency |
| ☐ | ☐ | ☐ | Other: |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | PSYCHIATRIC |
|---|---|---|---|
| ☐ | ☐ | ☐ | Addictions: Type: |
| ☐ | ☐ | ☐ | Alcohol abuse |
| ☐ | ☐ | ☐ | Anxiety |
| ☐ | ☐ | ☐ | Attention Deficit |
| ☐ | ☐ | ☐ | Depression |
| ☐ | ☐ | ☐ | Drug Abuse: Type: |
| ☐ | ☐ | ☐ | Mental retardation |
| ☐ | ☐ | ☐ | Obsessive / Compulsive |
| ☐ | ☐ | ☐ | Psychiatric treatment |
| ☐ | ☐ | ☐ | Autism |
| ☐ | ☐ | ☐ | Other: |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | GENITOURINARY / URINARY |
|---|---|---|---|
| ☐ | ☐ | ☐ | Dialysis |
| ☐ | ☐ | ☐ | Kidney Removal / Transplant |
| ☐ | ☐ | ☐ | Renal insufficiency / Failure |
| ☐ | ☐ | ☐ | Sexually Transmitted Disease |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | MUSCULOSKELETAL |
|---|---|---|---|
| ☐ | ☐ | ☐ | Artificial: ☐ Device ☐ Limb ☐ Joint |
| ☐ | ☐ | ☐ | Prosthesis Location: |
| ☐ | ☐ | ☐ | Cerebral Palsy |
| ☐ | ☐ | ☐ | Cystic Fibrosis |
| ☐ | ☐ | ☐ | Multiple Sclerosis |
| ☐ | ☐ | ☐ | Muscular Dystrophy |
| ☐ | ☐ | ☐ | Myasthenia Gravis |
| ☐ | ☐ | ☐ | Parkinson's Disease |
| ☐ | ☐ | ☐ | Psoriasis |
| ☐ | ☐ | ☐ | Rash |
| ☐ | ☐ | ☐ | Restless Leg Syndrome |
| ☐ | ☐ | ☐ | Osteopenia |
| ☐ | ☐ | ☐ | Osteoporosis |
| ☐ | ☐ | ☐ | Other: |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | OB/GYN |
|---|---|---|---|
| ☐ | ☐ | ☐ | Last menses? Date? |
| ☐ | ☐ | ☐ | Menopause |
| | | | **Pregnancy** |
| ☐ | ☐ | ☐ | Are you trying to get pregnant? |
| ☐ | ☐ | ☐ | Is it possible you are pregnant? |
| ☐ | ☐ | ☐ | If pregnant, What trimester? |
| ☐ | ☐ | ☐ | Do you take birth control pills? |

**IF YOU ARE USING ORAL CONTRACEPTIVES,** it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives and you can become pregnant, therefore you will need to use mechanical forms of birth control for at least one complete cycle. Please consult your physician for further guidance.

**Patient Signature:** **Witness:** **Date:** **Doctor:**

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| Yes | Past | No | ENDOCRINE |
|---|---|---|---|
| ☐ | ☐ | ☐ | Diabetes - Insulin Dependent |
| ☐ | ☐ | ☐ | Diabetes - Oral Medications |
| ☐ | ☐ | ☐ | Diabetes - Diet Controlled |
| ☐ | ☐ | ☐ | Diabetes - No Medications |
| ☐ | ☐ | ☐ | Diabetes - Uncontrolled |
| ☐ | ☐ | ☐ | Hyperthyroid |
| ☐ | ☐ | ☐ | Hypothyroid |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | NEUROLOGICAL |
|---|---|---|---|
| ☐ | ☐ | ☐ | Dementia / Alzheimer's |
| ☐ | ☐ | ☐ | Fainting |
| ☐ | ☐ | ☐ | Implantable Nerve Stimulator |
| ☐ | ☐ | ☐ | Numbness |
| ☐ | ☐ | ☐ | Seizures: Date: |
| ☐ | ☐ | ☐ | Stroke(s) Date: |
| ☐ | ☐ | ☐ | Transient Ischemic Attack (TIA) |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | GASTROINTESTINAL |
|---|---|---|---|
| ☐ | ☐ | ☐ | Hepatitis B or C |
| ☐ | ☐ | ☐ | Colitis / Diarrhea |
| ☐ | ☐ | ☐ | Acid Reflux |
| ☐ | ☐ | ☐ | GI ulcers or bleeding |
| ☐ | ☐ | ☐ | Crohns or Celiac disease |
| ☐ | ☐ | ☐ | Irritable Bowel Syndrome (IBS) |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | CARDIOVASCULAR |
|---|---|---|---|
| ☐ | ☐ | ☐ | Arrhythmias / Palpitations |
| ☐ | ☐ | ☐ | Artificial Heart Valves: Date: |
| ☐ | ☐ | ☐ | Blood pressure: high |
| ☐ | ☐ | ☐ | Blood pressure: low |
| ☐ | ☐ | ☐ | Cardiac Bypass: Date: |
| ☐ | ☐ | ☐ | Chest Pains / Angina |
| ☐ | ☐ | ☐ | Heart Attack: Date: |
| ☐ | ☐ | ☐ | Heart murmur |
| ☐ | ☐ | ☐ | Heart stents/drug-eluding: Date: |
| ☐ | ☐ | ☐ | Heart stents/bare metal: Date: |
| ☐ | ☐ | ☐ | Heart Surgery: Date: |
| ☐ | ☐ | ☐ | Implantable Defibrillator (AICD) |
| ☐ | ☐ | ☐ | Mitral valve prolapse (MVP) |
| ☐ | ☐ | ☐ | Pacemaker: Date: |
| ☐ | ☐ | ☐ | Shortness of Breath |
| ☐ | ☐ | ☐ | Wolff Parkinson White |
| ☐ | ☐ | ☐ | Other: |

| Yes | Past | No | RESPIRATORY |
|---|---|---|---|
| ☐ | ☐ | ☐ | Asthma: When? |
| ☐ | ☐ | ☐ | Asthma: Carry Current Inhaler? |
| ☐ | ☐ | ☐ | Asthma: Last Attack: Date: |
| ☐ | ☐ | ☐ | Asthma: Hospitalized? Date: |
| ☐ | ☐ | ☐ | Chronic Obstructive Pulmonary Disorder (COPD) |
| ☐ | ☐ | ☐ | Emphysema |
| ☐ | ☐ | ☐ | Obstructive Sleep Apnea / Snoring |
| ☐ | ☐ | ☐ | Lung removal / Transplant |
| ☐ | ☐ | ☐ | Shortness of Breath |
| ☐ | ☐ | ☐ | Previous tracheostomy |
| ☐ | ☐ | ☐ | Other: |
| ☐ | ☐ | ☐ | Other: |

## RESPIRATORY - EPWORTH SLEEP SCALE

Please note that this scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which can be a symptom of a sleep disorder.

Use the following scale to choose the most appropriate number for each situation listed below.

**0 = would never doze**
**1 = slight chance of dozing**
**2 = moderate chance of dozing**
**3 = high chance of dozing**

**Enter your choices, 0 - 3, in the boxes below**

| | |
|---|---|
| Sitting and reading? | |
| Watching television? | |
| Sitting inactive in a public place, like a theater or meeting? | |
| As a passenger in a car for an hour without a break? | |
| Lying down to rest in the afternoon? | |
| Sitting and talking to someone? | |
| Sitting quietly after lunch (when you had no alcohol)? | |
| In a car, while stopped in traffic? | |

**Enter your Epworth score total →**

| KEY | | |
|---|---|---|
| | 1 - 6 | Congratulations, you are getting enough sleep! |
| | 7 - 8 | Your score is average |
| | 9 & up | Seek the advice of a sleep specialist without delay |

**Please answer the following questions:**

I am overweight and find it difficult to lose weight… ☐ Yes ☐ No

I have been told that I snore loudly…… ☐ Yes ☐ No

I have been told that I gasp, snort or stop breathing at night…… ☐ Yes ☐ No

I have high blood pressure…… ☐ Yes ☐ No

Do you ever wake up with leg cramps or sore extremities?..... ☐ Yes ☐ No

Do you know if, or has someone told you that you kick, twitch, or thrash about during sleep?..... ☐ Yes ☐ No

Do you ever have palpitations or rapid thumping or pains in your chest?..... ☐ Yes ☐ No

Do you ever feel short of breath, light headed, or more exhausted then you should while at rest or with exercise?..... ☐ Yes ☐ No

Does your neck measure more than 15¾ inches for a women or 17 inches for men?..... ☐ Yes ☐ No

**Patient Signature:** **Witness:** **Date:** **Doctor:**

# DR. LYNN PIERRI'S OFFICE - PATIENT REGISTRATION

Name: DOB:

## PRESCRIPTION MEDICATIONS (Check all that apply)

☐ **I am not currently on any medications**

☐ **I am currently taking the following:**

### WHICH OF THESE BLOOD THINNERS DO YOU TAKE?

| Drug Name | Dose | Last Dose |
|---|---|---|
| ☐ Apixaban (Eliquis) | | |
| ☐ Aspirin (MD Directed) | | |
| ☐ Clopidogrel (Plavix) | | |
| ☐ Dabigatran (Pradaxa) | | |
| ☐ Dipyridamole (Aggrenox) | | |
| ☐ Edoxaban (Savaysa) | | |
| ☐ Prasugrel (Effient) | | |
| ☐ Rivaroxaban (Xarelto) | | |
| ☐ Ticagrelor (Brillinta) | | |
| ☐ Ticlopidine (Ticlid) | | |
| ☐ Warfarin (Coumadin, Jantoven) | | |
| ☐ Other: | | |
| ☐ Other: | | |
| ☐ None: | | |

### Vitamins/Supplements/Herbal/Holistic/Natural you take?

| Type | Drug Name | Dose |
|---|---|---|
| ☐ Vitamins | | |
| ☐ Glucosamine Chondroitin | | |
| ☐ St. John's Wart | | |
| ☐ Ginko Biloba | | |
| ☐ Ginseng | | |
| ☐ Supplements | | |
| ☐ Other: | | |
| ☐ Other: | | |
| ☐ None: | | |

### Non-prescription meds you take? (Over the Counter)

| | | |
|---|---|---|
| ☐ Aspirin (Self Directed) | | |
| ☐ Pain Reliever | | |
| ☐ Cold or Cough | | |
| ☐ Allergy Relief | | |
| ☐ Fish Oil | | |
| ☐ Sleeping Pills | | |
| ☐ Laxative | | |
| ☐ Diet Pill | | |
| ☐ Other: | | |
| ☐ Other: | | |
| ☐ None: | | |

### Prescription Medications You Currently Take

| Medications | Dose |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Which Bisphosphonate & Ligand inhibitors do you take?

| | | < 6 months | > 3 years |
|---|---|---|---|
| ☐ Aclasta (Zoledronic Acid) | ☐ IV | ☐ | ☐ |
| ☐ Actonel (Risedronate) | ☐ PO | ☐ | ☐ |
| ☐ Aredia (Pamidronate) | ☐ IV | ☐ | ☐ |
| ☐ Atelvia (Risedronate) | ☐ PO | ☐ | ☐ |
| ☐ Avastin (Bevacizumab) | ☐ PO ☐ IV | ☐ | ☐ |
| ☐ Boniva (Ibandronate) | ☐ PO ☐ IV | ☐ | ☐ |
| ☐ Calcium Carbonate (Risedronate) | ☐ PO | ☐ | ☐ |
| ☐ Cholecalciferol (Alendronate) | ☐ PO | ☐ | ☐ |
| ☐ Didronel (Etidronate) | ☐ PO | ☐ | ☐ |
| ☐ Evista (Raloxifene) | ☐ PO | ☐ | ☐ |
| ☐ Forteo (Teriparatide) | ☐ IV | ☐ | ☐ |
| ☐ Fosamax (Alendronate) | ☐ PO | ☐ | ☐ |
| ☐ Prolia (Denosumab) | ☐ IV | ☐ | ☐ |
| ☐ Reclast (Zoledronic Acid) | ☐ IV | ☐ | ☐ |
| ☐ Skelid (Tiludronate) | ☐ PO | ☐ | ☐ |
| ☐ Zometa (Zoledronic Acid) | ☐ IV | ☐ | ☐ |
| ☐ Xgeva (Denosumab) | ☐ IV | ☐ | ☐ |
| ☐ Other: | ☐ PO ☐ IV | ☐ | ☐ |

Why do you take bisphosphonates? Other:

☐ Osteoporosis ☐ Multiple Myeloma ☐ Breast Cancer

**Prolonged use of bisphosphonate therapy can lead to osteonecrosis of the jaw - a previously unrecognized and potentially serious complication.**

## ALLERGIES (check all that apply)

☐ **I have no known allergies**

☐ **I have the following allergies**

| Allergen | Reaction | Child | Adult |
|---|---|---|---|
| ☐ Advil | | ☐ | ☐ |
| ☐ Motrin-Ibuprofen | | ☐ | ☐ |
| ☐ Aspirin | | ☐ | ☐ |
| ☐ Cleocin | | ☐ | ☐ |
| ☐ Codeine/Narcotic | | ☐ | ☐ |
| ☐ Epinephrine | | ☐ | ☐ |
| ☐ Erythromycin | | ☐ | ☐ |
| ☐ Nitrous Oxide | | ☐ | ☐ |
| ☐ Penicillin | | ☐ | ☐ |
| ☐ Steroids | | ☐ | ☐ |
| ☐ Sulfa | | ☐ | ☐ |
| ☐ Valium | | ☐ | ☐ |
| ☐ X-ray contrast dye | | ☐ | ☐ |
| ☐ Latex | | ☐ | ☐ |
| ☐ Eggs | | ☐ | ☐ |
| ☐ Anesthetics | | ☐ | ☐ |
| Anesthetic Type: | | ☐ | ☐ |
| ☐ Other | | ☐ | ☐ |
| ☐ Other | | ☐ | ☐ |
| ☐ Other | | ☐ | ☐ |
| ☐ Other | | ☐ | ☐ |

**Patient Signature:** **Witness:** **Date:** **Doctor:**

Lynn Pierri DDS, MS
Caring Without Compromise™

**Patient HIPAA Awareness**

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services Office for Civil Rights, we are not permitted to release patient information except stated in the Notice of Privacy Practice, or in accordance with your wishes as stated below.

This waiver authorizes Lynn Pierri DDS, MS to send/give medical information as noted:
**Patient Name (First) _____ (Last)_____(Please Print)**

***Please answer the following, Circle Yes or No.***

1. **YES or NO** Leave a voice mail recording including my Personal Health Information on my home/cell phone.

2. **YES or NO** Speak to an individual of my choosing (Personal Representative) regarding my Personal Health and Billing information, and permit him/her to receive prescriptions and or test results on my behalf.
   **Name of Representative_____**
   **Relationship_____**
   **Phone Number_____**

3. **YES or NO** Speak to an individual in the event of a medical Emergency. _____(check if same as above)
   **Name of Emergency Contact _____**
   **Relationship_____**
   **Phone Number_____**

On this date_____, I received/reviewed Lynn Pierri DDS, MS' Notice of Privacy Practices, which describe how my medical information may be disclosed, and explains how I can get access to this information.

The authorizations made above will remain in effect until I notify Lynn Pierri DDS, MS in writing or by certified mail, of the requested changes.

_____ _____
Signature of Patient or Legal Guardian Patients Name (Please Print)

_____ _____
Print Name of Patient or Legal Guardian Today's Date

400 Townline Road, Suite 135, Hauppauge, NY11788 P: (631) 360-0266 F: (631) 360-0087
E: drpierri@lynnpierriddsms.com • www.lynnpierriddsms.com • www.dentalimplantsoflongisland.com

Lynn Pierri DDS, MS
Caring Without Compromise™

**Acceptance of Financial Responsibility**

I, _____, understand the procedure(s) or services being performed may not be covered or reimbursed under my medical and/or dental insurance policies(s). I understand and accept full financial responsibility if my insurance carrier does not cover, or refuses payment for services rendered by Lynn Pierri, DDS MS.

Should I have questions about my benefits, I will contact my insurance carrier directly.

*If I require a referral from my primary care physician, and have not provided a written referral to Lynn Pierri, DDS MS on or before my first visit, I understand the responsibility for all incurred charges is mine. You may bill me and I will forward you payment within thirty (30) days.

As per the NYS prompt payment law of January 22, 1998, your insurance carriers must respond to all claims within (45) forty-five days of submission. If your claims are not resolved within this forty-five day time frame, you must contact your insurance carrier to avoid full responsibility.

I understand if my insurance carrier denies my claim for any reason, I will be responsible for all charges within (30) thirty days. I further understand I may be subject to service and collection fees if payment for services rendered is not received with in this time period.

_____ _____

*Print full name* *Date*

_____

*Signature*

***Any claims submitted to your Insurance Company may be denied. If they deny payment, you are responsible for the fee _____***

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Lynn Pierri DDS, MS
Caring Without Compromise™

**Email Consent Form**

By providing my email address I agree to receive email communications
from Dr. Lynn Pierri and Living Well Essentials Spa.

I understand my email address will not be transferred to a third party or sold at any time.

Email addresses are collected for the sole purpose of communicating upcoming events and new services offered by our office only. Your personal information will never be included inside any email message.

Email address: _____

I have read and agree to the above.

_____ _____
Print Sign

Date: _____

**********

I do not agree to the above and do not wish to receive email communications.

_____ _____
Print Sign

Date: _____

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Lynn Pierri DDS, MS
Caring Without Compromise

**AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORDS**

Patient's Name: _____

Address: _____

Date of Birth: _____/_____/_____

I hereby request and authorize the release of all information, without limitations, regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future. This includes photocopies of medical and/or dental histories, x-ray findings, diagnosis, treatment, prognosis and financial records.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

Once Dr. Lynn Pierri gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

I request that you release the above information to:

Lynn Pierri, DDS, MS
(Fill in name of subsequent doctor or attorney)

400 Townline Road, Suite 135
Address

Hauppauge, NY 11788
City State Zip

_____
Patient's (or Legal Guardian's) Signature Date

_____
Witness' Signature Date