PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Cell Phone _____

Date _____ Home Phone _____

E-Mail Address _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: ❑ M ❑ F Age____ Birthdate_____ Driver's License#_____ ❑ Single ❑ Married ❑ Divorced

Patient Employed by _____ Patient Occupation_____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by_____ Occupation _____ Business Phone _____

Who is responsible for this account?_____ Relationship to Patient _____

Patient Social Security # _____ Spouse/Parent Social Security # _____

Dental Insurance Company 1) _____ 2) _____ Group #s _____

In Case of Emergency, Contact_____ Phone_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check all that apply)

- ❑ Heart Problems
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Circulatory Problems
- ❑ Nervous Problems
- ❑ Radiation Treatment
- ❑ Artificial Heart Valves or Joints
- ❑ Recent Weight Loss
- ❑ Back Problems
- ❑ Diabetes
- ❑ Latex Allergy
- ❑ Eye Surgery
- ❑ Respiratory Disease
- ❑ Epilepsy
- ❑ Headaches
- ❑ Hepatitis, Jaundice or Liver Disease
- ❑ Cancer
- ❑ Psychiatric Care
- ❑ Chronic Diarrhea
- ❑ Allergies to Anesthetics
- ❑ Allergies to Medicines or Drugs
- ❑ General Allergies
- ❑ Blood Disease
- ❑ Arthritis
- ❑ Special Diet
- ❑ Swollen Neck Glands
- ❑ Taking Bisphosphonate Drugs
- ❑ Sinus Problems
- ❑ A.I.D.S. or Other Immunosuppressive Disorders
- ❑ Stroke
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Chemical Dependency
- ❑ Hemophilia
- ❑ Taking Natural Supplements

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? _____

Are you taking ANY medication at this time? _____ If so, what? _____

Are you taking ANY supplements at this time? _____ If so, what? _____

Are you currently under the care of a physician? ❑ Yes ❑ No For what conditions? _____

If patient is a child, what is his/her weight? _____

Do you suspect that you are pregnant? ❑ Yes ❑ No Are you Nursing? ❑ Yes ❑ No

Is there anything else we should know about your medical history?_____

_____

_____

(over please)

PATIENT REGISTRATION & MEDICAL HISTORY

DENTAL HISTORY

Previous Dentist (if applicable) _____ City _____

Date of last cleaning _____ Date of last dental visit_____ Why?_____

Have you had dental x-rays taken during the past three years? ❑ Yes ❑ No If so, what kind: _____

❑ Bitewings (one or two on each side to detect cavities) Date_____

❑ Complete Series (16 x-rays) Date_____

❑ Panorex (sitting or standing and machine moves around head) Date_____

Is there any condition in your mouth that is causing you pain or discomfort? ❑ Yes ❑ No If yes, what kind:_____

_____

Do you do any of the following? (check all that apply)

❑ Bite cheeks or lips	❑ Suck fingers	❑ Breathe through mouth	❑ Drink tea/coffee
❑ Bite tongue	❑ Bite fingernails	❑ Tongue thrust	❑ Chew tobacco
❑ Clench teeth	❑ Suck thumb	❑ Notice bad breath frequently	❑ Smoke (cig/pipe)

Are you satisfied with the appearance of your teeth? ❑ Yes ❑ No

What can we do for you today?_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I may be entitled. I agree that I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with and assign directly to this office's providers, all benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Date Signature of Insured/Guardian

FINANCIAL AGREEMENT

By signing below I acknowledge the following: (1) I am responsible for any and all payments or co-payments for services rendered; (2) Any claims submitted to insurance, which are subsequently declined shall become my responsibility; (3) In the event my owed balance should become delinquent, I acknowledge I may additionally become responsible for additional fees including but not limited to: late fees, collection fees, interest, court costs and attorney fees.

_____ _____

Date Signature of Insured/Guardian

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental staff
Name of minor/child

to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____

Date Signature of Insured/Guardian