

PATIENT REGISTRATION

NAME _____ BIRTHDATE _____ SEX _____
LAST FIRST MIDDLE INITIAL

ARE YOU: (please circle one) MINOR SINGLE MARRIED

ADDRESS _____
NUMBER STREET CITY STATE ZIP

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DO YOU PREFER TO RECEIVE CALLS AT: HOME WORK EITHER EMAIL ADDRESS _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____

EMPLOYED BY _____
(Father, if child) Name of company Address

SPOUSE EMPLOYED BY _____
(Mother, if child) Name of company Address

IN CASE OF AN EMERGENCY CONTACT, Other than spouse: _____
Name Phone number

DENTAL INSURANCE _____
Type Under which name

REFERRED BY? _____

ARE OTHER IMMEDIATE FAMILY MEMBERS PATIENTS HERE? IF SO, WHO? _____

THANK YOU FOR ANSWERING THE FOLLOWING ACCURATELY AND COMPLETELY FOR YOUR HEALTH'S SAKE!

PLEASE CIRCLE:

1. ARE YOU HAVING PAIN OR DISCOMFORT AT THIS TIME?.....YES NO
2. HAVE YOU EVER HAD A BAD EXPERIENCE IN THE DENTAL OFFICE.....YES NO
3. HAVE YOU BEEN A PATIENT IN THE HOSPITAL DURING THE PAST TWO YEARS?YES NO
4. HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST 2 YRS?.....YES NO
5. ARE YOU ALLERGIC TO ANY MEDICATIONS?.....YES NO
- IF SO, PLEASE LIST: _____
6. HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT?.....YES NO
7. WHEN YOU WALK UP STAIRS OR TAKE A WALK. DO YOU HAVE TO STOP DUE TO SHORTNESS OF BREATH?.....YES NO
8. ARE YOU CURRENTLY TAKING ANY MEDICATIONS?.....YES NO
- IF SO, PLEASE LIST _____
9. DO YOU SMOKE? YES NO IF YES, HOW MANY PACKS PER DAY? _____ FOR HOW MANY YEARS? _____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT.

- | | | | | |
|--------------------------|--------------------|---------------------------------|--------------------------|--------------------------|
| Heart failure | Heart surgery | Sinus trouble | Pain in jaw joints | Cold sores |
| Heart disease or attack | Artificial joint | Allergies or hives | AIDS | Genital herpes |
| Angina pectoris | Anemia | Diabetes | Hepatitis A (infectious) | Epilepsy or seizures |
| Heart murmur | Stroke | Thyroid disease | Hepatitis B (serum) | Fainting or dizzy spells |
| High blood pressure | Kidney trouble | X-ray or cobalt treatment | Liver disease | Nervousness |
| Rheumatic fever | Ulcers | Chemotherapy (cancer, leukemia) | Yellow jaundice | Psychiatric treatment |
| Congenital heart lesions | Emphysema | Arthritis | Blood transfusion | Sickle cell disease |
| Scarlet fever | Chronic bronchitis | Rheumatism | Drug or alcohol abuse | Bruise easily |
| Artificial heart valve | Cough | Cortisone medicine | Hemophilia | Hay fever |
| Mitral valve prolapse | Tuberculosis (TB) | | Venereal disease | Glaucoma |
| Heart pacemaker | Asthma | | (syphilis, gonorrhea) | |

10. DO YOU EVER WAKE UP FROM SLEEP SHORT OF BREATH?..... YES NO
11. ARE YOU ON A SPECIAL DIET?..... YES NO
12. HAS YOUR MEDICAL DOCTOR EVER SAID YOU HAVE A CANCER OR TUMOR?.....YES NO
13. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED?.....YES NO
14. WOULD YOU LIKE YOUR TREATMENT DONE UNDER NITROUS OXIDE GAS?.....YES NO
15. WOMEN: ARE YOU PREGNANT NOW?.....YES NO
- ARE YOU TAKING ORAL CONTRACEPTIVES?..... YES NO
- DO YOU ANTICIPATE BECOMING PREGNANT?..... YES NO
16. WOULD YOU LIKE WHITER TEETH?..... YES NO
17. WOULD YOU LIKE FRESHER BREATH?..... YES NO

To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to my (or patient's) health. If I ever have any change in my health, or if my medications change, I will inform the doctor of dentistry at the next appointment without fail.

DATE _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____

-OVER-

Patient Name: _____ Date: _____

INSURANCE INFORMATION:

DENTAL INSURANCE CO _____ DENTAL INSURANCE CO PHONE# _____

DENTAL INSURANCE CO ADDRESS _____

NAME OF INSURED _____ BIRTHDATE OF INSURED _____

SS# OF INSURED _____ INSURED ID# _____ GROUP # _____

RELATIONSHIP TO PATIENT _____ INSURED'S EMPLOYER _____

***-DO YOU HAVE ADDITIONAL DENTAL INSURANCE? YES NO
IF YES, PLEASE COMPLETE THE FOLLOWING:***

DENTAL INSURANCE CO _____ DENTAL INSURANCE CO PHONE# _____

DENTAL INSURANCE CO ADDRESS _____

NAME OF INSURED _____ BIRTHDATE OF INSURED _____

SS# OF INSURED _____ INSURED ID# _____ GROUP # _____

RELATIONSHIP TO PATIENT _____ INSURED'S EMPLOYER _____

RESPONSIBLE PARTY:

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

(If patient is over 18, list patient. If patient is under 18, list parent or guardian responsible for payment)

RELATIONSHIP _____ BIRTHDATE _____ EMPLOYER _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____ SS# _____ DRIVER'S LICENCE# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

IF YOU ARE A COLLEGE STUDENT:

NAME OF COLLEGE _____ CITY _____ STATE _____

NUMBER OF CREDIT HOURS PER SEMESTER: _____ FULL-TIME/PART-TIME? _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist (or the 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 on behalf of my dependents.

SIGNATURE _____ DATE _____

Late charges: If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed may be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balance.