TIME: 8:27 am   date 12/7/2004

PATIENT REGISTRATION

Id: ___________ Chart ID: ___________________

First Name: ____ Last Name: ____

Patient is: ○ Policy Holder ○ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ____ Last Name: ____

Address: ____ Address 2: ____

City, State, Zip: ____ Pager: _________________________

Home Phone: ________________________ Work Phone: ____________________ Ext: ______ Cellular: ________________

Birth Date: __________________________ Soc. Sec: _______________________ Drivers Lic: ____________________________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ____ Address 2: ____

City: ___________________________________ State / Zip: _________________________ Pager: ________________________________

Home Phone: ________________________ Work Phone: ____________________ Ext: ______ Cellular: ______________________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced Separated ○ Widowed

Birth Date: _________________ Age: ________ Soc. Sec: ______________________ Drivers Lic: ____________________________

E-Mail: ____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full TimePart TimeRetired

Student Status: Full TimePart Time

Medicaid ID: ________________ Pref. Dentist: ________________________

Employer ID: ________________ Pref. Pharmacy: ______________________

Carrier ID: __________________ Pref. Hyg.: __________________________

Section 3

Cell #: __________________________

Emergency Contact: _______________________

Contact #: ______________________________

Primary Insurance Information

Name of Insured: ___________________________________ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ___________________________________ Insured Birth Date: ________________________

Employer: ____ Ins. Company: ____

Address: _________________________________ Address: ______________________________________

Address 2: ______________________________ Address 2: _____________________________________

City, State, Zip: _________________________________ City, State, Zip: ____

Rem. Benefits: ____________________________00 Rem. Deduct: ____________________________.00

Secondary Insurance Information

Name of Insured: _________________________________ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ___________________________________ Insured Birth Date: ________________________

Employer: ____ Ins. Company: ____

Address: _________________________________ Address: ______________________________________

Address 2: ______________________________ Address 2: _____________________________________

City, State, Zip: _________________________________ City, State, Zip: ____

Rem. Benefits: ____________________________00 Rem. Deduct: ____________________________.00

Today's Family Dentistry

MEDICAL HISTORY

PATIENT NAME ____ Birth Date _____________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now: ○Yes ○No If yes, please explain: ____

Have you ever been hospitalized or had a major operation: ○Yes ○No If yes, please explain: ____

Have you ever had a serious head or neck injury: ○Yes ○No If yes, please explain: ____

Are you taking any medications, pills, or drugs? ○Yes ○No If yes, please explain: ____

Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○No ____

Are you on a special diet? ○Yes ○No ____

Do you use Tobacco? ○Yes ○No

Do you use controlled substances: ○Yes ○No

Women: Are you:
○Pregnant/Trying to get pregnant? ○Nursing:
○Taking oral contraceptives:

Are you allergic to any of the following:

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics

○ Other If yes, please explain: ____

Do you have, or have you had, any of the following:

○ AIDS/HIV Positive	○ Chest Pains	○ Frequent Headaches	○ Irregular Heartbeat	○ Scarlet Fever
○ Alzheimer's Disease	○ Cold Sores/Fever Blister	○ Genital Herpes	○ Kidney Problems	○ Shingles
○ Anaphylaxis	○ Congenital Heart Disorder	○ Glaucoma	○ Leukemia	○ Sickle Cell Disease
○ Anemia	○ Convulsions	○ Hay Fever	○ Liver Disease	○ Sinus Trouble
○ Angina	○ Cortisone Medicine	○ Heart Attach/Failure	○ Low Blood Pressure	○ Spina Bifida
○ Arthritis/Gout	○ Diabetes	○ Heart Murmur	○ Lung Disease	○ Stomach/Intestinal Disease
○ Artificial Heart Valve	○ Drug Addiction	○ Heart Pace Maker	○ Mitral Valve Prolapse	○ Stroke
○ Artificial Joint	○ Easily Winded	○ Heart Trouble/Disease	○ Pain in Jaw Joints	○ Swelling of Limbs
○ Asthma	○ Emphysema	○ Hemophilia	○ Parathyroid Disease	○ Thyroid Disease
○ Blood Disease	○ Epilepsy or Seizures	○ Hepatitis A	○ Psychiatric Care	○ Tonsillitis
○ Blood Transfusion	○ Excessive Bleeding	○ Hepatitis B or C	○ Radiation Treatments	○ Tuberculosis
○ Breathing Problem	○ Excessive Thirst	○ Herpes	○ Recent Weight Loss	○ Tumors or Growths
○ Bruise Easily	○ Fainting Spells/Dizziness	○ High Blood Pressure	○ Renal Dialysis	○ Ulcers
○ Cancer	○ Frequent Cough	○ Hives or Rash	○ Rheumatic Fever	○ Venereal Disease
○ Chemotherapy	○ Frequent Diarrhea	○ Hypoglycemia	○ Rheumatism	○ Yellow Jaundice

Have you ever had any serious illness not listed above? ○Yes ○No If yes, please explain: ______________________________

Comments: ____

____

HOW DID YOU HEAR ABOUT US?
WHO REFERRED YOU?

____

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

____ __________
Signed (Patient – see reverse) Date

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

____ __________
Signed (Employee/authorized patient) Date

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN ____ DATE ______________________