PLEASE PRINT ABOVE LINE

Patient Registration

DATE

NAME: (LAST) (FIRST) (MIDDLE) NAME YOU WOULD LIKE TO BE CALLED

ADDRESS (STREET) (CITY, STATE, ZIP)

HOME PHONE CELL PHONE E-MAIL

SINGLE☐ MARRIED☐ WIDOWED☐ DIVORCED☐

BIRTH DATE SEX MARITAL STATUS HOBBIES OR INTERESTS

SOCIAL SECURITY NUMBER DRIVERS LICENSE NUMBER OCCUPATION

EMPLOYED BY ADDRESS BUS. PHONE

NAME OF SPOUSE/PARENT OCCUPATION

EMPLOYED BY ADDRESS BUS. PHONE

NAME OF PERSON RESPONSIBLE FOR ACCOUNT SOCIAL SECURITY NUMBER DRIVERS LICENSE NUMBER

DENTAL INSURANCE ADDRESS PHONE

POLICY HOLDER RELATIONSHIP DATE OF BIRTH SOCIAL SECURITY NUMBER GROUP POLICY NUMBER

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? RELATIONSHIP

NAME OF PHONE # OF CONTACT PERSON, NOT IN IMMEDIATE FAMILY IN CASE OF AN EMERGENCY?

DENTAL

REASON FOR VISIT? WHY DID YOU CHOOSE *DR. HIRSCHBERG* AS YOUR DENTIST?

DATE OF LAST VISIT? WHY DID YOU LEAVE YOUR DENTIST?

EXCELLENT☐ GOOD☐ FAIR☐ POOR☐ EXCELLENT☐ GOOD☐ FAIR☐ POOR☐

HOW WOULD YOU EVALUATE YOUR PRESENT DENTAL HEALTH? WHAT WOULD YOU LIKE IT TO BE?

1 2 3 4 5 6 7 8 9 10 ORTHODONTIA☐ ENDONDONTIA☐ PERIODONTIA☐

ON A SCALE OF 1-10 (10 BEING THE HIGHEST) WHAT PRIORITY DO YOU GIVE YOUR TEETH? HAVE YOU EVER HAD?

1 2 3 4 5 6 7 8 9 10

ON A SCALE OF 1-10 WHAT FEAR OR ANXIETY DO YOU HAVE ABOUT DENTISTRY?

	YES	NO
ARE YOU COMPLETELY SATISFIED WITH YOUR TEETH AND THEIR APPEARANCE?	☐	☐
DO YOU GET FRUSTRATED BECAUSE YOU ALWAYS HAVE SOMETHING TO BE TREATED OR REPAIRED WHEN YOU VISIT A DENTIST?	☐	☐
DO YOU WANT TO LEARN TO CONTROL DENTAL DISEASE AND RETAIN YOUR TEETH?	☐	☐

IF YOU COULD CHANGE ONE THING ABOUT YOUR MOUTH, WHAT WOULD THAT BE?

(OVER PLEASE)

MEDICAL

EXCELLENT☐ GOOD☐ FAIR☐ POOR☐

HOW WOULD YOU EVALUATE YOUR RECENT MEDICAL HEALTH?

NAME AND ADDRESS OF PHYSICIAN

DATE OF LAST COMPLETE PHYSICAL | ARE YOU TAKING ANY MEDICATION NOW? | FOR WHAT PURPOSE?

PLEASE LIST ALL MEDICATIONS

DO YOU HAVE NOW OR HAVE YOU EVER HAD

	YES	NO
Heart disease	☐	☐
Rheumatic fever or heart murmur	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Sinus trouble	☐	☐
Allergies to drugs	☐	☐
Allergy to novacaine	☐	☐

Please specify:

	YES	NO
Blood transfusion	☐	☐
Tuberculosis or Lung disease	☐	☐
Jaundice or Hepatitis	☐	☐
Ulcers	☐	☐
Arthritis	☐	☐
Epilepsy	☐	☐
Excessive bleeding	☐	☐

	YES	NO
Artificial joint	☐	☐
AIDS/HIV pos	☐	☐
Psychiatric care/emotional problems	☐	☐
Are you pregnant or anticipating it	☐	☐
Drug or alcohol addiction	☐	☐
Shortness of breath	☐	☐
10 lb. weight change in 1 year	☐	☐

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE:

CONSENT: The undersigned hereby authorizes Dr. Hirschberg to take X-rays, study models, photographs, or any other diagnostic aids deem appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, rent, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

PAYMENT: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. MasterCard & Visa are accepted.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, "upon receipt of full (or partial) payment of bill." We do not render our services on the basis that insurance companies will pay our entire fee.

MEDICAL: The above medical history is accurate, and I understand that it is my responsibility to immediately inform the office of any changes in health or medication.

I fully understand all of the above and will allow Dr. Hirschberg to verify my medical history in order to best treat my dental needs.

SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS MINOR) | DATE