PATIENT REGISTRATION

Patient ID:_____ Date: _____

First Name: _____Last Name: _____Middle Initial: _____
Patient is : □ Responsible Party □ Policy Holder Preferred Name: _____

Responsible Party*: if someone other than the patient*
First Name: _____Last Name: _____Middle Initial: _____
Address: _____Address 2: _____
City_____, State_____, Zip: _____ E-mail: _____
Home Phone: _____Work Phone: _____Cell Phone: _____
Birth date: _____Social Security #: _____Drivers Lic#: _____
○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _____Address 2: _____
City_____, State_____, Zip: _____E-mail: _____
Home Phone: _____Work Phone: _____Cell Phone: _____
Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed
Birth date: _____Social Security #: _____Drivers Lic#: _____
(section 2):
Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed
Student Status: ○Full Time ○ Part Time
Referred By:_____ Phone: _____
Nearest Relative Not Living With You: _____Relationship: _____
Address: _____Zip: _____Phone: _____
Are you currently having dental problems? _____
_____
What are your concerns? *Circle as many as applicable* :(Pain Avoidance) (Appearance) (Losing Teeth) (Gum/Periodontal Disease) (Cavities) (Oral Cancer) (Wasting / Exceeding Dental Insurance Limits) (Your General Health) (Routine Checkup) (Cleaning)
Any Other concerns? _____

Primary Insurance Information:
Name of Insured: _____Relationship to Insured: ○Self ○Spouse ○Child ○ Other
Employer ID: _____Carrier ID: _____
Insured Social Security #: _____Insured Birth date: _____
Employer: _____Insurance Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip:_____ City, State, Zip: _____

Secondary Insurance Information:
Name of Insured: _____Relationship to Insured: ○Self ○Spouse ○Child ○ Other
Employer ID: _____Carrier ID:_____
Insured Social Security #: _____Insured Birth date:_____
Employer:_____Insurance Company:_____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

I Understand That Payments Is Due At Time Of Service. I will pay today by:
CASH □ CHECK □ CREDIT CARD □
I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

Signature _____ **Date** _____

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
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? Yes No
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No
Do you need to pre-medicate? Yes No If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

_____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
									Yellow Jaundice	Yes	No

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

_____

_____

Comments: _____

_____

_____

_____

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 _____