Randolph & Associates
FAMILY DENTISTRY

Patient Registration

PLEASE PRINT

OFFICE USE ONLY
Date Completed _____
Dates Updated _____
_____
_____

MR.
MRS.
MISS.

PATIENT | LAST NAME | FIRST NAME | MIDDLE | BIRTHDATE

STREET ADDRESS | CITY | STATE | ZIP

BEST DAYTIME CONTACT PHONE | GENDER | MARITAL STATUS | NUMBER OF DEPENDENTS

EMPLOYER | EMPLOYER'S ADDRESS | OCCUPATION | BUSINESS PHONE

SPOUSE NAME | EMPLOYER | EMPLOYER'S ADDRESS | EMPLOYER PHONE

PARENT'S NAME (IF APPLICABLE) | EMPLOYER | EMPLOYER'S ADDRESS | EMPLOYER PHONE

NEAREST FRIEND OR RELATIVE (NOT LIVING WITH PATIENT) | RELATIONSHIP TO PATIENT | PHONE

WHO MAY WE THANK FOR REFERRING YOU?

Dental Insurance Information

IF PATIENT IS NOT RESPONSIBLE FOR THE BILL, PLEASE LIST WHO IS RESPONSIBLE.

NAME | ADDRESS | CITY | STATE | ZIP

HOME PHONE | RELATIONSHIP TO PATIENT | OCCUPATION

EMPLOYER | EMPLOYER'S ADDRESS | CITY | STATE | ZIP | BUS. PHONE

Primary Insurance

INSURED'S DATE OF BIRTH

EMPLOYEE'S NAME | SSAN

EMPLOYER | ADDRESS

INSURANCE COMPANY | ADDRESS

SUBSCRIBER # | GROUP # | POLICY #

Secondary Insurance

INSURED'S DATE OF BIRTH

EMPLOYEE'S NAME | SSAN

EMPLOYER | ADDRESS

INSURANCE COMPANY | ADDRESS

SUBSCRIBER # | GROUP # | POLICY #

I AGREE TO PAY THE COSTS OF COLLECTION OF ANY UNPAID BALANCE, WHICH INCLUDE A 35% COLLECTION AGENCY FEE AND ANY COURT OR ATTORNEY FEES INCURRED TO COLLECT ANY OUTSTANDING AMOUNT.

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE DR(S). _____ TO RELEASE TO YOUR COMPANY, OR A REPRESENTATIVE, ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF THIS DENTAL CARE.

ASSIGNMENT OF BENEFITS

I ALSO AUTHORIZE AND REQUEST YOUR COMPANY TO PAY DIRECTLY TO THE ABOVE NAMED DOCTOR THE AMOUNT DUE ME IN MY PENDING CLAIM FOR TREATMENT OR SERVICES, BY REASON OF SUCH TREATMENT OR SERVICES RENDERED TO.

PATIENT'S SIGNATURE | DATE

SIGNATURE OF INSURED | DATE

Medical History

PHYSICIAN'S NAME ADDRESS

DATE OF LAST PHYSICAL EXAM ANY MAJOR CHANGES IN GENERAL HEALTH WITHIN THE PAST YEAR?

SURGICAL HISTORY	DATE

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING NOW.

MEDICATION	INDICATION	MEDICATION	INDICATION

PLEASE LIST ALLERGIES (LATEX, ANESTHETICS, PENICILLIN, ASPIRIN, CODEINE, SEASONAL, METAL, FOODS, ETC.)

CIRCLE ANY OF THE FOLLOWING CONDITIONS OR HEALTH COMPLICATIONS YOU HAVE EVER EXPERIENCED.

HEART DISEASE	STROKE	TUBERCULOSIS	GI DISORDER	SINUS DISORDER
HEART SURGERY	PULMONARY EMBOLISM	JAUNDICE/LIVER DISEASE	ARTHRITIS	PREGNANT
PACEMAKER	CIRCULATORY DISORDER	HEPATITIS A/B/C	OSTEOPOROSIS MEDICATION	CANCER
CHEST PAIN/ANGINA	BLEEDING DISORDER	DIABETES TP1/TP2	JOINT REPLACEMENT	RADIATION/CHEMO.
HEART MURMUR/MVP	ANTICOAGULANT USE	THYROID DISEASE	EPILEPSY/SEIZURES	AIDS/HIV POSITIVE
HIGH BLOOD PRESSURE	COPD	KIDNEY DISEASE	ANXIETY/DEPRESSION	DRUG/ALCOHOL ABUSE
HEART ATTACK	ASTHMA	ULCERS	PSYCHIATRIC CARE	SMOKING/TOBACCO USE

OTHER/EXPLAIN

YOUR SIGNATURE

WE REQUEST THAT YOU PLEASE KEEP US INFORMED OF YOUR CURRENT HEALTH STATUS AND MEDICATION LIST.

Dental History

HOW LONG SINCE YOUR LAST VISIT TO A DENTIST?

DO YOU BRUSH YOUR TEETH DAILY? ☐ YES ☐ NO

HOW LONG DO YOU USE A TOOTHBRUSH BEFORE REPLACING?

DO YOU USE: ☐ DENTAL FLOSS ☐ WATER JET?

DO YOUR GUMS BLEED? ☐ YES ☐ NO

HAVE YOU HAD DEEP CLEANINGS? ☐ YES ☐ NO

DO YOU HAVE DENTAL ANXIETY? ☐ YES ☐ NO

DO YOU HAVE DENTAL PAIN? ☐ YES ☐ NO

ARE YOU AWARE OF ANY SWELLING OR LUMP IN YOUR MOUTH? ☐ YES ☐ NO

DO YOU GRIND OR CLENCH YOUR TEETH? ☐ YES ☐ NO

DO YOU HAVE ANY CLICKING, POPPING, OR PAIN IN OR AROUND YOUR JAW JOINTS (TMJS)? ☐ YES ☐ NO

Youth Section

HOW OFTEN DOES YOUR CHILD BRUSH HIS OR HER TEETH? DO YOU ASSIST? ☐ YES ☐ NO

INDICATE IF CHILD HAS ANY MOUTH HABITS (THUMB SUCKING, NAIL BITING, MOUTH BREATHING, ETC.)

INDICATE IF CHILD USES FLOURIDE IN ANY FORM. ☐ WATER ☐ PILLS ☐ VITAMINS ☐ TOOTHPASTE ☐ ORAL RINSE ☐ GEL