ACCOUNT REGISTRATION

Please Print Legibly

PERSON RESPONSIBLE FOR ACCOUNT

Last Name			First Name M.I.		Sex M / F	Birthdate
Home Phone	Work Phone		Cell Phone	Pager		E-mail Address
Address			City		State	Zip Code
Own or Rent?	Length of Residence?	Previous address if less than 3 years				Marital Status (circle) Married Single Divorced Widowed Separated
Employer Name		Employer Address			City State	
Occupation			Social Security No#		Drivers License No#	
Whom may we thank for referring you? Phone Book, Live in Area, Relative, Friend, Co-Worker, Neighbor.						

SPOUSE INFORMATION

Last Name			First Name M.I.	Sex M / F	Birthdate
Address			City State		Zip Code
Home Phone	Cell Phone		Work Phone	Drivers License No#	
Employer Name		Employer Address		City State	
Social Security No#			Occupation		

DEPENDENT INFORMATION

Last Name	First Name M.I.	Sex	Birthdate
1			
2			
3			
4			

INSURANCE INFORMATION

RESPONSIBLE PERSON'S INSURANCE INFORMATION		SPOUSE'S INSURANCE INFORMATION	
Insurance Company Name and Address		Insurance Company Name and Address	
Who is Covered?(circle) Husband Wife Dependents 1 2 3 4		Who is Covered?(circle) Husband Wife Dependents 1 2 3 4	
S.S. No# of Insured		S. S. No# of Insured	
Ins Phone No#	Group No#	Ins Phone No#	Group No#

NOTIFY IN CASE OF EMERGENCY (Specify someone that does not live in your household)

Name	Address	Telephone No #	Relationship

AUTHORIZATION AND RELEASE

I authorize my insurance company to pay to the Dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the Dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Responsible Person's Signature

Date

DENTAL HEALTH HISTORY

Patient Name: ____ Age __________

Date of last visit to dentist:____

Are you dissatisfied with the appearance of your teeth?
Do you have a toothache?
Do your gums bleed easily?
Do you clench or grind your teeth frequently?
Do your joints pop or click?
Do your jaws ever feel tired?
Do you have any pain in jaw joints?
Do you have ringing or fullness in your ears?
Headaches, if yes how often ____________
Loose teeth?
Broken or chipped teeth or fillings?
Are you aware of bad breath?
Dry mouth?
Teeth sensitive to: Hot foods or liquids? Cold food or liquids? Sweets?
Are you aware of an uncomfortable bite?
Does food catch between your teeth?
Have you had braces?
Have you ever been treated by a Periodontist (Gum Disease)
Do you prefer to save your teeth?
Do you want complete dental care?

Why did you leave your last dentist? ____

____

Please list your sports, activities and hobbies ____

____

Patient or Parent's signature ________________________________ Date _______________

MEDICAL HEALTH HISTORY

NAME ________________________________ AGE _______ DOB ___________ Sex M or F

Physician's Name & Phone Number ________________________________ Date of Last Visit __________

____

Check if you have, or have had, any of the following:

- ☐ Artificial Heart Valve
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Stent
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Cancer/Tumor
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ Steroid Treatment
- ☐ Blood Disease/Disorder
- ☐ Arthritis, Rheumatism
- ☐ Hip or Knee Replacement
- ☐ Other Joint Replacement
- ☐ HIV-positive
- ☐ AIDS
- ☐ Hepatitis
- ☐ Chemical Dependency
- ☐ Sexually Transmitted Disease
- ☐ Headaches/Migraines
- ☐ Depression
- ☐ Psychiatric Care
- ☐ Neurological Disorder
- ☐ Asthma
- ☐ Cough (Persistent)
- ☐ Respiratory Disease
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Ulcer
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Stroke(s)
- ☐ Tuberculosis
- ☐ Thyroid Problems
- ☐ Tobacco Habit _______
- ☐ History of drug/alcohol abuse
- ☐ Latex Allergy

(Women) Are you pregnant? ☐ Yes ☐ No Due____________ Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Have you had any serious illnesses, conditions or operations? ☐ No ☐ Yes (If yes, describe) __________________

____

____

MEDICATIONS:

List medications you are currently taking and reason:

____
____
____
____
____
____
____

DRUG ALLERGIES/REACTIONS

____
____
____
____
____
____
____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that omitting or providing incorrect information can be dangerous to my health.

____ ________________________

Signature of Patient (Or Parent if a minor) **Date**

MEDICAL HISTORY UPDATES – (Office use only)

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