West Alabama Dental Implant Center

Patient Registration

First Name:_____ **Last Name:**_____ **Soc.Security#:**_____

Preferred Name:_____ Patient is: ____Policy Holder _____Responsible Party

Whom may we thank for referring you to our office:_____

1) Patient Information:

Address:_____ City:_____ St/Zip:_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Birth Date:_____ Age:_____ Driver's Lic#:_____ Email: _____

Emergency Contact:_____ Phone #_____

Employment Status: ___Full Time ___Part Time ___Retired

Student Status: ____Full Time ____Part Time

Employer _____ (Provide copy of Student ID)

Address_____ Name of School:_____

Previous Employer:_____ Current grade:_____

2) Responsible Party (*if someone other than the patient*)

First Name:_____ Last Name:_____ Soc. Security#_____

Address:_____ City:_____ St/Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth Date: _____ Age:_____ Driver's Lic:_____

Employer:_____ Relation to Patient:_____

3) Primary Insurance Information (provide current card)

Name of Insured:_____ Relationship to Insured ___Self ___Spouse ___Child

Insured Soc. Sec#:_____ Insured Birth Date: _____

Insurance Co:_____ Employer:_____

ID #_____Group#_____

Is patient covered by additional insurance? Yes/No

Subscribers Name _____

Birth Date:_____ Soc Sec # _____

Relationship to Patient _____

Insurance Co_____

Group #_____ ID# _____

4) Dental History:

Previous Dentist:_____

Last visit date:_____

Are you happy with your smile?_____

Have you lost any teeth? _____ reason_____

Do your gums bleed easily? _____

Are gums swollen or tender?_____

Do you use tobacco products? _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to Dr. J. David Aswell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature of all insurance submissions.

The above named dentist may use my health care information and mey disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative.

Date_____ Relation to Patient_____

MEDICAL HISTORY

Reason for your visit today:_____

Are you allergic to any of the following:

___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetics

___Other Please list:_____

Do You Take Blood Thinners: Aspirin Plavix Coumidin Other_____

****List ALL** other medications you are taking:_____

_____

Ladies only: ***Medical Alert***

Have you ever taken any of the following bisphosphonates? *(circle any that apply*) Fosamax, Bonefos, Ostac, Didronel, Boniva, Aredia, Evista, Actonel, Forteo, Skelid, Zometa NO_____

___Are you pregnant/trying to get pregnant? ____Taking oral contraceptives?

Do you have or have you had any of the following? *(Check all that apply)*

__AIDS/HIV Positive
__Alzheimer's Disease
__Anemia
__Angina
__Arthritis/Gout
__Artificial Heart Valve
__**Artificial Joint**
__Asthma
__Blood Disease
__Blood Transfusion
__Breathing Problem
__Bruise Easily
__Cancer
__Chemotherapy
__Chest Pains
__Cold Sores/Fever Blister
__Congenital Heart Dise.
__Diabetes
__Drug Addiction
__Easily Winded
__Emphysema
__Epilepsy/Seizures
__Excessive Bleeding
__Fainting Spells
__Frequent Headaches
__Glaucoma
__Hay Fever
__**Heart Attack**
Date_____
__Heart Murmur
__Heart Pace Maker
__Heart Disease
__Hemophilia
__Hepatitis A
__**Hepatitis B or C**
__Herpes
__**High Blood Pressure**
__Hives or Rash
__Irregular Heartbeat
__Kidney Problems
__Leukemia
__Liver Disease
__Low Blood Pressure
__Lung Disease
__Mitral Valve Prolapse
__Pain in Jaw Joints
__Psychiatric Care
__Radiation Treatment
__Renal Dialysis
__**Rheumatic Fever**
__Rheumatism
__Scarlet Fever
__Shingles
__Sickle Cell Disease
__Sinus Trouble
__Stomach Ulcer
__**Stroke**
Date_____
__Swelling of Limbs
__Thyroid Disease
__Tonsillitis
__Tuberculosis
__Tumors/Growths
__Ulcers (mouth)
__Venereal Disease
__Yellow Jaundice
__Other_____
_____
_____

Have you had any other serious physical illness not listed above?_____

Have you been in the hospital in the last 5 years for any reason? (explain)_____

Name of your physician:_____ Date of last visit:_____
Preferred Pharmacy:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information 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 GUARDAN_____
DATE_____