



Patient Registration

First Name: Last Name: Middle Initial:

Preferred Patient Name:

Patient Is: Policy Holder for Insurance
Is covered under someone else's insurance policy

Patient Information

Mailing Address:
City, State, Zip:
Home Phone: Work Phone: Ext: Pager: Cell Phone:
Sex: Male Female Martial Status: Married Single Divorced Separated Widowed
Birth Date: Age: Soc. Sec: Drivers Lic:
E-mail:

Employment Status: Full Time Part Time Retired
Student Status (if over 18) Full Time Part Time (Proof may be required by your insurance company before a claim can be paid)
Who can we thank for referring you to us?

Preferred Dentist:
Preferred Pharmacy:
In case of Emergency, please contact: Relationship to Patient:
Home Phone: Work Phone: Cell Phone:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:
City, State, Zip:
Home Phone: Work Phone: Ext: Pager: Cell Phone:
Birth Date: Soc. Sec: Drivers Lic:

Responsible Party has patient covered under their insurance
Primary Insurance Policy Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of Policy Holder: Relationship to Patient: Self Spouse Child Other
Policy Holder's Soc. Sec: Policy Holder's Birth Date:
Policy Holder's Employer: Insurance Co:
Address: Address:
City, State, Zip: City, State, Zip:

Are you allowed to receive phone calls at work to confirm an appointment? yes no

Secondary Insurance Information

Name of Policy Holder: Relationship to Patient: Self Spouse Child Other
Policy Holder's Soc. Sec: Policy Holder's Birth Date:
Policy Holder's Employer: Insurance Co:
Address: Address:
City, State, Zip: City, State, Zip:

## MEDICAL HISTORY

Are you under a physicians 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 \_\_\_\_\_

Are you on a special diet?  Yes  No \_\_\_\_\_

Do you use tobacco?  Yes  No \_\_\_\_\_

Do you use controlled substances?  Yes  No \_\_\_\_\_

Woman: Are you \_\_\_\_\_

Pregnant/Trying to get pregnant?  Nursing?

Taking oral contraceptives?

Are you allergic to any of the following? \_\_\_\_\_

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Other: If yes, please explain: \_\_\_\_\_

Do you have or have you had any of the following? \_\_\_\_\_

<input type="checkbox"/> AIDS/HIV positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortizone Medicine	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Mitro Valve Prolapse	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Herpes	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice

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

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that all 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 other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% charge(18% APR) may be added to my account.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

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.

***A broken appointment fee may be added to my account without a 48 hour cancellation hour.***

Signature \_\_\_\_\_ Date \_\_\_\_\_