Mark R. Driver, D.M.D., P.C.
Benjamin Driver, D.M.D.
Jennifer M. Driver, D.M.D.
1651 NW Hughwood Ct.
Roseburg, Oregon 97471
(541) 672-8187

Patient Registration and Health History

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE	EMAIL:		1
NAME			
SPOUSE			
ADDRESS			
CITY/STATE/ZIP			
HOME PHONE No.	CELL PHONE NO.		
BIRTHDATE	AGE		
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY No.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE		
NAME		
ADDRESS		
CITY/STATE/ZIP		
HOME PHONE No.		
BIRTHDATE	AGE	GRADE
SCHOOL		

IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO.

DENTAL INSURANCE	2
PRIMARY CARRIER	
INSURANCE COMPANY	
INSURANCE ADDRESS	
EMPLOYER	
EMPLOYEE	BIRTHDATE
GROUP No.	
EMPLOYEE ID NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
INSURANCE ADDRESS	
EMPLOYER	
EMPLOYEE	BIRTHDATE
GROUP No.	
EMPLOYEE ID NO.	

ACCOUNT INFORMATION	4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
DRIVER'S LICENSE NO.	
BANK	
BRANCH	
YOUR:	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE	EXT.
YOUR SPOUSE'S:	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE	EXT.

GETTING TO KNOW YOU	3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
THEIR NAME:	
REFERRED TO US BY	
YOUR FORMER ADDRESS	
CITY/STATE/ZIP	
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CITY/STATE/ZIP	
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY/STATE/ZIP	

HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   Physician's Name _____
   Address _____ Phone # _____
6. Have you ever taken or are you scheduled to be taking any oral or IV form of bisphosphonate medications including alendronate (Fosamax®) or risedronate (Actonel®) ..... YES NO
   If yes, please explain: _____
7. Are you now taking any medication, drugs or pills? ..... YES NO
   If yes, please list all non-prescription & prescription medications: _____
   _____
8. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO
   If yes, please list: _____
   What is the reaction? _____
9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES NO	Emphysema	YES NO	Abnormal Bleeding	YES NO
Heart Disease or Attack	YES NO	Cough	YES NO	Blood Transfusion	YES NO
Angina Pectoris	YES NO	Tuberculosis (TB)	YES NO	Drug Addiction	YES NO
High Blood Pressure	YES NO	Asthma	YES NO	Chronic Pain	YES NO
Heart Murmur	YES NO	Sinus Trouble	YES NO	Sexually Transmitted Disease (Syphilis, Gonorrhea)	YES NO
Mitral Valve Prolapse	YES NO	Allergies or Hives	YES NO		
Rheumatic Fever	YES NO	Diabetes	YES NO	Cold Sores	YES NO
Congenital Heart Defect	YES NO	Thyroid Disease	YES NO	Sleep Disorder	YES NO
Rheumatic Fever	YES NO	Alcohol Dependency	YES NO	Fainting or Dizzy Spells	YES NO
Artificial Heart Valve	YES NO	Tobacco Use	YES NO	Epilepsy or Seizures	YES NO
Heart Pacemaker	YES NO	Cancer/Chemotherapy/Radiation	YES NO	Mental Health Disorder	YES NO
Heart Surgery	YES NO	Arthritis	YES NO	Nervousness	YES NO
Artificial Joints (Hip, Knee)	YES NO	Autoimmune Disorder	YES NO	Eating Disorder	YES NO
Anemia	YES NO	Steroid Therapy	YES NO	Osteoporosis	YES NO
Stroke	YES NO	Glaucoma	YES NO	GE Reflux	YES NO
Kidney Trouble	YES NO	Pain in Jaw Joints	YES NO	Gastrointestinal Disease	YES NO
Ulcers	YES NO	A.I.D.S. or H.I.V.	YES NO	Severe or Rapid Weight Loss	YES NO
Cosmetic Surgery	YES NO	Hepatitis or Liver Disease	YES NO		

10. Do you have any disease, condition, or problem not listed? ..... YES NO

    Specify: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, due date: _____. Are you taking birth control pills? ☐ Yes ☐ No

Comments: _____

_____

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature: _____ Date ____/____/____

CONSENT:

The undersigned hereby authorizes Driver Dentistry and its staff to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Driver Dentistry to make a thorough diagnosis of the patient's dental needs. I also authorize Driver Dentistry to perform any and all forms of agreed upon treatment, including referrals and records sent to specialist, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Service provided in this office for myself or dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date ____/____/____

Parent or Responsible Party _____ Relationship to Patient _____