PATIENT REGISTRATION

PATIENT NAME_____SOC SEC # _____ DOB_____

PARENT OR SPOUSE _____SOC SEC # _____ DOB_____

MAILING ADDRESS _____CITY_____ ST ____ ZIP _____

EMAIL ADDRESS:_____NICKNAME_____

HOME PHONE_____ WORK PHONE_____ CELL _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

PATIENT EMPLOYER_____OCCUPATION_____

SPOUSE EMPLOYER _____OCCUPATION_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ PHONE _____

PRIMARY DENTAL INS _____ADDRESS_____

GROUP NO. _____ SUBSCRIBER NO._____ INS CO. PHONE _____

SECONDARY DENTAL INS _____ADDRESS_____

GROUP NO. _____ SUBSCRIBER NO._____ INS CO. PHONE _____

PERSON TO CONTACT IN CASE OF EMERGENCY_____ PHONE _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing within thirty (30) days of billing date. In the event it should become necessary to place for collection any unpaid balance due for services rendered to me or my family, I/we agree to pay collection fees, and should legal action be filed, reasonable attorney fees, filing fees, and any other costs the court determines proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to the office where applicable, but without their assuming responsibility for the collection thereof. If need be, I agree to pay rebilling charges of 1% per month for balances over 30 days and any broken appointment charges when less than 48 hours notice has been given.

A copy of this agreement is as valid as the original.

The above information is for the purpose of obtaining credit and is warranted to be true. I authorize creditor or his agent to make a credit investigation, including employment verification.

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your rights.

SIGNATURE _____ DATE_____

(PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR. POWER OF ATTORNEY MUST BE PRESENTED, IF NECESSARY.)

MEDICAL HISTORY

PATIENT NAME _____ DOB _____

GENERAL HEALTH: Excellent ☐ Good ☐ Fair ☐ Poor ☐ DATE OF LAST PHYSICAL _____

NAME OF PHYSICIAN(S) _____ PHONE _____

ARE YOU UNDER TREATMENT FOR ANY CURRENT CONDITION? **Y N** WHAT CONDITION? _____

PLEASE LIST ALL MEDICATIONS: _____

HAVE YOU EVER BEEN TREATED FOR OR BEEN INFORMED YOU HAVE ANY OF THE FOLLOWING:

YES	NO		YES	NO	
☐	☐	Heart Murmur	☐	☐	Asthma
☐	☐	Heart Problems	☐	☐	Anemia
☐	☐	Pacemaker	☐	☐	Arthritis
☐	☐	High Blood Pressure	☐	☐	Epilepsy or Seizures
☐	☐	Diabetes	☐	☐	Ulcer
☐	☐	Stroke	☐	☐	Excessive Bleeding
☐	☐	Rheumatic Fever	☐	☐	Venereal Disease
☐	☐	Kidney Involvement	☐	☐	Recurring Open Sores
☐	☐	Liver Involvement	☐	☐	Artificial Joints, Valves, etc. ____
☐	☐	Lung Involvement	☐	☐	Cancer Type _____
☐	☐	Tuberculosis	☐	☐	Other Conditions_____
☐	☐	Hepatitis TYPE _____			

☐ ☐ Are you taking or have taken Bisphosphonates (Fosamax, Actonel, Boniva, Didronel, Zometa or Aredia for osteoporosis, chemotherapy for multiple myeloma, breast cancer, bone metastasis or Paget's disease)?

HAVE YOU HAD OR DO YOU PLAN ON HAVING AN H.I.V. (AIDS) TEST? **Y N** IF YES, RESULTS _____

HAVE YOU EVER HAD RADIATION OR CHEMOTHERAPY? **Y N** ARE YOU SUBJECT TO FAINTING SPELLS? **Y N**

DO YOU USE TOBACCO? **Y N** HOW MUCH? _____ HOW MUCH ALCOHOL TO YOU CONSUME PER DAY? _____

WOMEN: ARE YOU PREGNANT? **Y N** IF YES, DUE DATE? _____ IF NO, ARE YOU TAKING BIRTH CONTROL? **Y N**

HAVE YOU EVER BEEN TOLD YOU WERE ALLERGIC TO:

YES	NO	
☐	☐	Penicillin
☐	☐	Local anesthetics
☐	☐	Latex

PLEASE LIST ANY OTHER DRUG ALLERGIES _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT _____ NAME/PHONE LAST DENTIST _____

LAST DENTAL VISIT _____ LAST X-RAYS _____ ANY OUTSTANDING DENTAL NEEDS **Y N**

ANY PROBLEMS WITH PAST DENTAL TREATMENT? _____

DO YOU FLOSS ON A REGULAR BASIS? Y N DO YOUR GUMS BLEED WHILE FLOSSING/BRUSHING? Y N

DO YOU CLENCH/GRIND YOUR TEETH? Y N DO YOU FEEL PAIN WHEN EATING HOT, COLD, SWEETS? Y N

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____

(PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR. POWER OF ATTORNEY MUST BE PRESENTED, IF NECESSARY.)

MEDICAL UPDATE, FOR OFFICE USE ONLY

DATE	CHANGES (IF ANY)	B.P./PULSE RESP.	INITIALS	DATE	CHANGES (IF ANY)	B.P./PULSE RESP.	INITIALS