

# PATIENT REGISTRATION

Patient Name (Last, First, MI)				Name you prefer to be called		Home Phone		Work Phone		Cell Phone		
Current Street Address					City			State	Zip		How long?	
Marital Status		Sex		Patient Social Security Number			Birth Date		Age			
S	M	W	D	F	M							
Patient's Employer				Employer's Address			City		State	Zip		
Spouse's Name				Spouse's Work Phone			HOW DID YOU HEAR ABOUT US?					
Name of nearest relative not living with you and their relationship to you:						Phone Number						

## Account Information

Person Responsible for bill (Last, First, MI)					Home Phone		Daytime Phone			
Address			City		State	Zip		Social Security #		Birth Date

## DENTAL INSURANCE INFORMATION

### Primary Insurance

Name of Insured			Sex	Social Security #		Birth Date	Employer Phone		
			M / F						
Name of Plan (Employer)			Group #	Name of Ins. Co.			Ins. Co. Phone #		
Insurance Address			City		State	Zip		Relationship to Patient	

### Secondary Insurance

Name of Insured			Sex	Social Security #		Birth Date	Employer Phone		
			M / F						
Name of Plan (Employer)			Group #	Name of Ins. Co.			Ins. Co. Phone #		
Insurance Address			City		State	Zip		Relationship to Patient	

**CHECK ONE AND SIGN**

A. I hereby release any information relating to any dental claims and I authorize the insurance company to issue payment to the doctor for any claims.

Signature \_\_\_\_\_

B. I hereby release any information relating to any dental claims and intend to pay the entire bill myself at the time services are rendered and have the insurance company reimburse me.

Signature \_\_\_\_\_

Fees are to be paid at the time services are rendered. If you need arrangements please discuss with the secretary prior to treatment. No question is too small to ask. Feel free to call or come by anytime.

\_\_\_\_\_  
Responsible Party Signature

# PATIENT HEALTH HISTORY

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_

Purpose of Appointment \_\_\_\_\_

Date of last dental exam \_\_\_\_\_

Date of last medical exam \_\_\_\_\_

Have you been in the hospital in the last five years? \_\_\_\_\_

If so, for what? \_\_\_\_\_

Do you have or have you ever had:

- |                              |                              |                             |
|------------------------------|------------------------------|-----------------------------|
| Hip or Joint Replacement     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Jaundice                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy/Seizures            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rheumatic Fever              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Disease                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Murmur                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abnormal Heart Condition     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abnormal Bleeding from a Cut | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Venereal Disease             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| AIDS/HIV                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Recurring Illnesses          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ulcers                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unintentional Weight Loss    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Allergies:

- |                     |                              |                             |
|---------------------|------------------------------|-----------------------------|
| to Penicillin       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| to Local Anesthetic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| to Medications      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| to Latex            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Any Other Allergies \_\_\_\_\_

Please answer yes or no to the following questions:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Are you having or have you ever had radiation treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you smoke or use smokeless tobacco?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you use drugs and/or alcohol?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (Women) Are you pregnant?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you taking any medication?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If so, what? \_\_\_\_\_

Other Physical Conditions \_\_\_\_\_

Blood pressure (if known) \_\_\_\_\_ / \_\_\_\_\_

Name of Physician \_\_\_\_\_

Physician Phone \_\_\_\_\_

Are you under the care of a physician now? \_\_\_\_\_

If so, nature of care? \_\_\_\_\_

Signature of person filling out history \_\_\_\_\_

Signature of person reviewing this history \_\_\_\_\_

**FOR OFFICE USE:**