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?

Email Address

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 the nearest relative not living with you and the 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 M / F	Social Security #	Birth Date	Employer Phone

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 M / F	Social Security #	Birth Date	Employer Phone

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? ______________________

FOR OFFICE USE:

Do you have or have you ever had:

Hip or Joint Replacement	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Abnormal Heart Condition	☐ Yes	☐ No
Abnormal Bleeding from a Cut	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No
Recurring Illnesses	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Unintentional Weight Loss	☐ Yes	☐ No

Allergies:

to Penicillin	☐ Yes	☐ No
to Local Anesthetic	☐ Yes	☐ No
to Medications	☐ Yes	☐ No
to Latex	☐ Yes	☐ No

Any Other Allergies ______________________

Please answer yes or no to the following questions:

Are you having or have you ever had radiation treatment?	☐ Yes	☐ No
Do you smoke or use smokeless tobacco?	☐ Yes	☐ No
Do you use drugs and/or alcohol?	☐ Yes	☐ No
(Women) Are you pregnant?	☐ Yes	☐ No
Are you taking any medication?	☐ Yes	☐ 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 ______________________