Date _____

PATIENT REGISTRATION

Patient's Name _____ Date of Birth _____ SS# _____

Name of Spouse _____ Date of Birth _____ SS# _____

If a Child, Parent's Name _____ Date of Birth _____ SS# _____

Street _____ Phone ( )_____

City _____ State _____ Zip _____ Driver's License# _____

E-Mail _____ Cell Phone ( ) _____

Patient Employed by _____ Phone ( ) _____

Spouse Employed by _____ Phone ( ) _____

In Case of Emergency. who should be notified _____ Phone ( ) _____

Person Responsible for this account _____

Who may we thank for referring you _____

APPOINTMENTS:

Scheduled appointments are reserved specifically for each patient. We request a 24 hour notice if you need to cancel your appointment and reserve the right to charge a broken appointment fee if proper notice is not given.

FINANCIAL AND INSURANCE:

Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service.

As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full.

HIPPA

I, _____, have had full opportunity to read and consider the contents of the Consent for Use and Disclosure of Health Information as well as the Notice of Privacy Practices. I understand that I am giving my consent for the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

SIGNATURE: _____

DENTAL INSURANCE

Name of Insured person _____

Insured Person's Date of Birth _____ Insured Person's SS# _____

Name of Insurance Company _____ Policy No. _____

How will you be paying: CASH _____ CHECK _____ CREDITCARD _____ MEDICAID _____

I, the undersigned, authorize treatment to be rendered and assume financial responsibility. I acknowledge that, unless other arrangements are made, all charges for treatment are due at the time treatment is rendered. I understand that a delinquent balance may be subject to a 1.5% monthly finance charge. Any collection and/or attorney's fees incurred to collect this account will be borne by the account.

_____

Signature of Patient or Responsible Party

DENTAL HISTORY

Why are you now seeking dental treatment? _____

Date of last dental visit _____

Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

Have you ever had any serious trouble associated with previous dental treatment? _____

HEALTH HISTORY

Please answer each question. Check yes or no. If in doubt, leave blank ..... YES ☐ NO ☐

1. Are you now under the care of a physician .....
   If so, what is the condition being treated? _____
2. Have you ever been hospitalized or had a serious illness? .....
   If yes, explain _____
3. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? .....
4. Women are you pregnant? .....
   If so, give due date _____
5. Do you use tobacco in any form? .....
   If yes, how much? _____
6. Do you use alcoholic beverages (more than 2 drinks per day)? .....
7. Do you have or have you ever had any of the following?

CARDIOVASCULAR	Yes	No
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Mitral Valve Prolapse	☐	☐
Congenital Heart Defect	☐	☐
Angina (Chest Pain)	☐	☐
Heart Attack	☐	☐
Arrythmia (Irregular Beat)	☐	☐
Congestive Heart Failure	☐	☐
Heart Surgery	☐	☐
Stints	☐	☐
Pacemaker	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Stroke	☐	☐
Other	☐	☐
RESPIRATORY		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Difficulty Breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Hyperthyroidism	☐	☐
Hypothyroidism	☐	☐

BLOOD DISORDERS	Yes	No
Anemia	☐	☐
Do you bruise easily	☐	☐
Blood Transfusion	☐	☐
KIDNEY DISEASE		
Kidney Infection	☐	☐
Kidney Surgery	☐	☐
NERVOUS SYSTEM		
Convulsions / Epilepsy	☐	☐
Dizziness / Fainting	☐	☐
Psychiatric Treatment	☐	☐
INFECTIOUS DISEASES		
Hepatitis ☐ A ☐ B ☐ C	☐	☐
Venereal Disease	☐	☐
HIV	☐	☐
Miscellaneous	☐	☐
Liver Disease	☐	☐
Arthritis / Rheumatism	☐	☐
Ulcers	☐	☐
Glaucoma	☐	☐
Tumors or Growths	☐	☐
Cancer	☐	☐
Radiation Treatment	☐	☐
Prosthetic Joints / Surgery	☐	☐
Have you ever been told to pre-medicate for prosthetic joints?	☐	☐

ALLERGIES	Yes	No
Latex	☐	☐
Aspirin	☐	☐
Penicillin	☐	☐
Codeine / Hydrocodone	☐	☐
Sulfa Drugs	☐	☐
Local anthesthetics (e.g. Novocain)	☐	☐
Barbituates / Sedatives / Sleeping Pills	☐	☐
Other Allergies _____	☐	☐

8. Are you taking any of the following?

Antibiotics / Sulfa Drugs	☐	☐
Osteoporosis Medications	☐	☐
Blood Thinners	☐	☐
Blood Pressure Medications	☐	☐
Thyroid Medication	☐	☐
Cortisone / Steroids / Cold Remedies	☐	☐
Tranquilizers	☐	☐
Insulin / other Diabetes Drugs	☐	☐
Recreational Drugs	☐	☐
Digitalis / other Heart Medication	☐	☐
Nitroglycerin	☐	☐
Aspirin	☐	☐
Birth Control Pills	☐	☐
Other Medications LIST BELOW	☐	☐

_____

LIST ANY CURRENT MEDICATION AND DOSAGE

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

10. Physician Name _____ Phone _____

Is there is any disease or condition not listed above that you think we should know about?

_____

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient,
Parent or Guardian _____ Date _____

DATE	#		