PATIENT REGISTRATION

PATIENT INFORMATION

Date_____

Name_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Age _____Birthdate_____ Sex: ☐ Male ☐ Female Social Security #_____
Home Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail Address: _____
Employer: _____ Employment Status: ☐ Full Time ☐ Part Time ☐ Retired
Employers Address: _____ Occupation_____
School Name: _____ Location:_____ Student Status: ☐ Full Time ☐ Part Time
In case of an emergency, who may we contact? Name _____Phone_____
Whom may we thank for referring you? _____

RESPONSIBLE PARTY (if someone other than the patient)

Name _____ Relationship _____
Home Address: _____City, State, Zip: _____
Home Phone: _____Work Phone: _____Cell Phone:_____
Employer: _____ Employment Status: ☐ Full Time ☐ Part Time ☐ Retired
Employers Address: _____Occupation: _____

DENTAL INSURANCE INFORMATION

Do you have dental insurance? ☐ Yes ☐ No

Primary
Insurance Company:_____ Employer:_____
Dental Claims Mailing Address: _____ Group #_____
Name of Insured:_____ Insured Birthdate:_____
Insured Social Security #: _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary
Insurance Company: _____Employer:_____
Dental Claims Mailing Address: _____Group #_____
Name of Insured: _____ Insured Birthdate_____
Insured Social Security # _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

We plan all appointments carefully in advance and strive hard to stay on schedule and minimize waiting. Please help us by being on time and also by calling us at least 24 hours in advance if you need to change an appointment. Unless we are notified that you cannot make your dental appointment, you may be subject to a charge for missed appointments.
I am responsible for this account, including all balances unpaid by my insurance. Accounts in which there has been no monthly payment, and no financial arrangements have been made, may be subject to a 1.5% monthly service charge.

_____ _____
Patient (Parent) Signature Date

MEDICAL HISTORY

Are you under physician's care now ? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain:_____

Have you had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, how much: _____

Do you use street drugs? ☐ Yes ☐ No

Do you need to be pre-medicated for dental appointments? ☐ Yes ☐ No
(for example: artificial joints, hip/knee replacements, rheumatic fever, heart murmur, mitral valve prolapse)

Women: Are you…….
Pregnant/trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to or have you had a reaction to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ General Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

Aids/HIV Positive	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Alzheimer's	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Radiation treatments	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No			Rheumatic Fever	☐ Yes ☐ No
				Sinus Trouble	☐ Yes ☐ No
				Stroke	☐ Yes ☐ No
				Thyroid Problems	☐ Yes ☐ No
				Tuberculosis	☐ Yes ☐ No

Have you ever had any serious illness not listed? ☐ Yes ☐ No
If yes, please explain:_____

When was your last dental appointment? _____

Are you experiencing any discomfort with your teeth today? ☐ Yes ☐ No

I understand that this form is strictly confidential. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Thank you for your time and cooperation.

Signature of Patient, Parent, or Guardian_____Date_____