PATIENT REGISTRATION AND MEDICAL HISTORY

Today's Date______________ (Please Print) Cell Phone ________________
Home Phone________________

Patient____
Last Name First name Middle Initial Preferred Name

Mailing Address______________________________ Lot/Apt________ City___________________ State_____ Zip__________

Street Address______________________________ Lot/Apt________ City_________________ State_______ Zip__________

Sex {}M {}F Age_______ Birthdate________________ {}Single {}Married {}Widowed {}Separated {}Divorced

Employed by____ Occupation________________

Business Address____ Business Phone__________________

Spouse/Parent Name____ Spouse/Parent Birthdate____________

Spouse/Parent Employed by____ Occupation__________________

Business Address____ Business Phone______________

Who is responsible for this account?____________________________________ Relationship to Patient______________

Patient's Social Security #____________________________ Spouse/Parent Social Security #___________________

Name of Primary Dental Insurance Company____ Group #______________

Insured Name________________________________ Insured DOB _________________ Subscriber ID#_______________

Name of Secondary Dental Insurance Company______________________________________ Group #______________

Insured Name________________________________ Insured DOB ________________ Subscriber ID#________________

Emergency Contact Name of Relative or Person **NOT LIVING with you**___________________________Ph______________

Whom may we thank for referring you?_______________________| Email - ___________________________

MEDICAL HISTORY

Physcian's Name___________________________________ Date of Last Physical______________________________

Have you ever had any of the following? (check boxes that apply)

{}Heart Problems
{}High Blood Pressure
{}Low Blood Pressure
{}Circulatory Problems
{}Nervous Problems
{}Radiation Treatment
{}Artificial Heart Valves or Joints
{}Back Problems
{}Diabetes
{}Need Antibiotic Prior to Dental Work
{}Epilepsy
{}Hepatitis,Jaundice,Liver Disease
{}Cancer
{}Psychiatric Care
{}Allergies to Anesthetics
{}Allergies to Medicine or Drugs
{}General Allergies
{}Blood Disease
{}Arthritis
{}Respiratory Disease
{}Rheumatic Fever
{}Sinus Problems
{}"A.I.D.S." or Other Immunosuppressive Disorders
{}Stroke
{}Venereal Disease
{}Chemical Dependency
{}Hemophilia,Prolonged Bleeding
{}Subject to Fainting
{}Drug or Substance Addiction

Do you have any drug allergies or have you ever had an adverse reaction to any medication?____________________

If so, what____

Have you ever responded adversely to medical or dental treatment?____________________________________

Are you currently taking a blood thinner? {}Yes {}No If so, what______________________________________

Are you taking any other medication at this time? {}Yes {}No If so, what_____________________________

Are you under the care of a physician? {}Yes {}No For what conditions?_______________________________

If patient is a child, what is his/her weight?__________

(Women)Do you suspect that you are pregnant? {}Yes {}No How far?___________ Are you nursing? {}Yes {}No

Is there anything else we should know about your medical history?____________________________________

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform this office of future changes in my medical history,dental insurance and contact information.

Signature ____ *Date*__________________

DENTAL HISTORY

Reason for today's visit? ______________________________

Last Dental Visit ______________________________________

How often do you brush? _____________________

What dental aids do you use? [] Floss, [] Water Pick, [] Toothpick, [] Electric / Sonicare Toothbrush,
[] Perio Aid, [] Other_______________

When used properly, do you believe in the dental benefits of Fluoride? [ ] Yes [ ] No

Please check any of the following which apply to you:

[ ] Gums bleed during brushing or flossing
[ ] Pain with brushing or flossing
[ ] Frequent sensitivity to cold, ot or sweets
[ ] Usually break fillings or teeth
[ ] Jaws frequently feel tired or sore
[ ] Regularly clench or grind your teeth
[ ] Bad odors or tastes in mouth
[ ] Gums feel tender or swollen
[ ] Food frequently gets caught between teeth
[ ] Previous (or current) Periodontal (gum) surgery
[ ] Pain with biting or chewing
[ ] Previous (or current) biopsy of the mouth, lips or face
[ ] Frequent cold sores, blisters or other oral / lip lesions
[ ] Previous (or current) injury or trauma to your teeth, mouth or face

CONSENT FOR TREATMENT (Please sign unless you have any questions)

I hereby authorize this Dental Practice to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Insurance Release:

I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Financial Responsibility for Payment:

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child.
I accept full financial responsibilty for all charges not covered by insurance. I will pay for services if they exceed the insurance benefit limitations.
The undersigned further agrees to pay a finance charge of 1 1/2% per month on the unpaid balance of this account.
In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection of sums due and unpaid for the work herein set forth.

Signature ____ Date ______________________________

MINORS OR CHILD CONSENT

Because (name of child) ______________________________ is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment.

Signature ____ Date ______________________________