PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT) Home Phone _____

Patient_____
Last Name First Name Initial Preferred Name

E-mail Address:_____Cell Phone_____

Street Address_____ City_____ State_____ Zip _____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by_____ Occupation_____

Business Address_____ Business Phone _____

Spouse Name_____ Spouse Birthdate _____

Spouse Employed by_____ Occupation_____

Business Address_____ Business Phone _____

Social Security #_____ Spouse's Social Security #_____

Name of Dental Insurance Company_____ Group Number_____

In case of emergency, who should be notified?_____ Phone _____

Whom may we thank for referring you? _____

What is the reason for your visit today? _____

Date of last Dental Visit _____ last Dental Cleaning _____ last Full Mouth x-rays _____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical _____

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

- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints ☐ premed
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Latex Allergy
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Mitral Valve Prolapse ☐ premed
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Epinephrine (Allergy/Reaction)
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ AIDS/HIV
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

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 taking any medication at this time?_____ If so, what _____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions?_____

(Woman) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

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.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of_____do hereby request

Name of minor/child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____

Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

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 responsibility for all charges not covered by insurance.

_____ _____

Date *Signature of Insured/Guardian*