

PATIENT REGISTRATION AND MEDICAL HISTORY

E-mail: _____ Cell Phone _____ Home Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ 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 _____

Social Security # _____ Spouse/Parent Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

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

Who may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> "A.I.D.S." or Other |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Chronic Diarrhea | Immunosuppressive Disorders |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Allergies to Medicine or Drugs | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> 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? _____

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

(Women) Do you suspect that you are pregnant? Yes No

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.

Date _____ Signature _____

(OVER)

ASSIGNMENT AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me, my spouse, or my child during the period of such Dental care to third party payors and/or other health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to myself, my dependents or spouse.

Signature of patient or parent if minor

Date

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment.

Late Charges

Please check the option which you prefer.

Co-Payment due in full at each appointment.

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize the failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount, or any future outstanding account balances.

_____ Cash

_____ Personal Check

_____ Credit Card _____ Visa _____ MC _____ Discover

_____ DocPay

_____ CareCredit

_____ I wish to discuss the dental office's policy

Signature of patient or parent if minor

Date

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Date

Signature of patient or parent if minor

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Date

Signature of patient or parent if minor