PATIENT REGISTRATION

Date: _____

First Name: _____ Last Name: _____ Middle Initial_____

Preferred Name: _____

Patient Information

Address _____ City, State, Zip _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

Birth Date: _____ Age: _____ SS#: _____ Drivers Lic#: _____

Place of Employment _____

Employment Status: ❍ Full Time ❍ Part Time ❍ Retired _____

Student Status: ❍ Full Time ❍ Part Time Grade _____

Spouse: _____ Birth Date: _____

Place of Employment _____

Responsible Party ❍ Patient ❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

First Name: _____ Last Name: _____ Middle Initial: _____

Address _____ City, State, Zip _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ❍ Male ❍ Female Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

Birth Date: _____ SS#: _____ Drivers Lic #: _____

Spouse: _____ Birth Date: _____

Primary Dental Insurance Information

Name of Primary Insured: _____ Relationship to Patient: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured SS#: _____ Birth Date: _____

Employer: _____ Insurance Co. Name: _____

Address: _____ Claims Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone #: _____

Secondary Dental Insurance Information

Name of Primary Insured: _____ Relationship to Patient: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured SS#: _____ Birth Date: _____

Employer: _____ Insurance Co. Name: _____

Address: _____ Claims Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone #: _____

OVER PLEASE

Are you under a 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 ever 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 list: _____

_____

_____

Do you take, or have you taken, Phen-Fen or Redux ❍ Yes ❍ No If yes, please explain: _____

Do you use tobacco? ❍ Yes ❍ No

Women: Are you

❑ Pregnant/Trying to get pregnant? ❑ Nursing ❑ Taking oral contraceptives

Are You allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Sulfa

❑ Other If yes, please explain: _____

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

❑ AIDS/HIV Positive
❑ Alzheimer's Disease
❑ Artificial Heart Valve
❑ Artificial Joint
❑ Asthma
❑ Blood Disease
❑ Cancer
❑ Chemotherapy
❑ Convulsions
❑ Diabetes
❑ Drug Addiction
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Fainting Spells/Dizziness
❑ Frequent Headaches
❑ Heart Attack/Failure
❑ Heart Murmur
❑ Heart Pace Maker
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High Blood Pressure
❑ Hypoglycemia
❑ Kidney Problems
❑ Leukemia
❑ Liver Disease
❑ Mitral Valve Prolapse
❑ Psychiatric Care
❑ Radiation Treatments
❑ Renal Dialysis
❑ Rheumatic Fever
❑ Sinus Trouble
❑ Stroke
❑ Tonsillitis
❑ Tuberculosis
❑ Venereal Disease

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

_____

Comments: _____

_____

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. I also understand the use of anesthetic agents emobodies a certain risk, I understand that responsibility for payment for Dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial agreements have been made.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

I have reviewed or received a copy of this office's Notice of Privacy Practices

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Revised 10/16