Patient Registration Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Circle One Gender: F / M Status: Single / Married / Divorced / Child / Other

Social Security #: _____ Birth Date: _____

Home Phone: _____ Work: _____ Ext: _____ Cell: _____

Address: _____
City State Zip Code

Referred By: _____

E-mail Address: _____

If you are completing this form for another person, what is your relationship to that person? _____

Health Information

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you taking any medicine(s) including non-prescriptive medicine?.....Yes No

   If so, what medicine(s) are you taking?_____

2. Name of Physician: _____Phone: _____

3. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease ..... Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke(circle))..... Yes No
   c. High blood pressure or low blood pressure ..... Yes No

4. Do you have any artificial joints or implants? (Hip, knee replacements) ..... Yes No

5. Have you ever been prescribed antibiotics for any dental visit? ..... Yes No

   If so, what is your premedication regimen _____

6.. Do you have or have you had any of the following diseases or problems?
   a. Sinus Trouble, asthma or hay fever (circle) ..... Yes No
   b. Fainting spells, seizures or epilepsy (circle) ..... Yes No
   c. Diabetes..... Yes No
   d. Hepatitis, jaundice or other liver problems..... Yes No
   e. AIDS or HIV infection; sexually transmitted disease ..... Yes No
   f. Thyroid problems..... Yes No
   g. Respiratory problems (emphysema, bronchitis, etc.)..... Yes No
   h. Arthritis or painful, swollen joints..... Yes No
   i. Stomach ulcer..... Yes No
   j. Kidney trouble..... Yes No
   k. Tuberculosis..... Yes No
   l. Swollen glands in the neck ..... Yes No
   m. Problems with mental health..... Yes No
   n. Cancer/ treatment for cancerous growth..... Yes No
   o. Problems of the immune system..... Yes No
   p. Have you ever required a blood transfusion? ..... Yes No
   q. Do you have any blood disorder such as anemia? ..... Yes No

7. Are you allergic or have you had a reaction to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or other antibiotics..... Yes No
   c. Sulfa Drugs, Aspirin, Iodine..... Yes No
   d. Codeine or Demerol..... Yes No
   e. Latex, jewelry ..... Yes No

8. Do you or have you ever used tobacco products? ……Yes No

9. Have you ever had any complications following dental treatment? ……Yes No

   If so, explain _____

10. Do you have any disease, condition, or problem not listed that you think we should know about? Yes No

    If so, explain _____

11. Are you wearing removable dental appliances? ……Yes No

12. Have you been admitted to a hospital or needed emergency care during the past two years? …… Yes No

    If yes, please explain: _____

13. Are you now under the care of a physician? ……..Yes No

    If yes, please explain: _____

WOMEN

14. Are you pregnant? ……..…… Yes No

    If so, due date _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have any changes regarding my health, I will inform the staff at my next appointment.

_____ Date: _____

Signature of patient, parent or guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment # City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

Insurance Information

Primary Only

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID/SS #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services and Use/Disclosure of Health Information

A copy of our Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

The patient is responsible for any disallowed amounts by their insurance company.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

I have received a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand that by signing this consent form, I am acknowledging receipt of said Privacy Practices and I am giving my consent to your use and disclosure of my protected health information to carry out treatment/payment activities and health care operations.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian