PATIENT REGISTRATION FORM

(This information is necessary for our files and your health and will be considered **CONFIDENTIAL**)

Last Name ______________________________ First ______________________________ Mi ________ M F

I prefer to be called: ______________________________ Birthday: ____/____/______ Age: ______________ Single Married Divorced

Social Security #: ______________________________ Drivers License#: ______________________________ Widowed Separated

Home Address: ____
Street City State Zip

Home Phone #: ( ) ____________________ Work Phone #: ( ) ____________________ Ext.: ________ Cell #: ______________________

Whom may we Thank for referring you? ____

Patient's Employer: ______________________________ Occupation: ______________________________

Employer's Address: ____
Street City State Zip

If patient is a student-Name of school: ____

Neighbor or Relative not living with you

His/Her Name: ______________________ Relation: ______________________ Home Phone #.: ( ) ______________

Address: ____ Work Phone #.: ( ) ______________
Street City State Zip

Person Responsible for Account if other than Yourself

Name: ______________________ Relation: ______________________ Home Phone #.: ( ) ______________

Employer: ______________________ Work Phone #: ______________ Ext.: ________ Driver's License #: ______________________

Billing Address: ____
Street City State Zip

Spouse/Parent Information

Name: ______________________ Birthday: ____/____/______ Social Security #.: ______________________

Employer: ______________________ Work Phone #: ( ) ______________ Ext.: ________ Driver's License #: ______________________

Dental Insurance Information

Primary Insurance

Insurance Co. Name: ______________________ Phone #: ( ) ______________________ Group#: ______________________

Insurance Co. Address: ____
Street City State Zip

Insureds' Name: ______________________ SS#: ______________ Insureds' Birthday.: ____/____/______ Relation: ______________

Insureds' Employer: ______________________ Employer Address: ______________________________________
Street City State Zip

Secondary Insurance

Insurance Co. Name: ______________________ Phone #: ( ) ______________________ Group#: ______________________

Insurance Co. Address: ____
Street City State Zip

Insured's Name: ______________________ SS#: ______________ Insured's Birthday.: ____/____/______ Relation: ______________

Insured's Employer: ______________________ Employer Address: ______________________________________
Street City State Zip

PATIENT RESPONSIBLE FOR FEES: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid within 30 days of the date on which examinations are provided. I hereby authorize that the payment from any insurance company due me be paid directly to the working practice In the event of default in payment patient or party responsible for fees agree to pay any and all costs of suit, collection and attorney's fees.

By signing below I consent to the dental treatment provided by this practice. The information provided is accurate to the best of my knowledge.

Signature - Patient or Responsible Party ____ Date ______________________

HEALTH QUESTIONNAIRE

MEDICAL HISTORY

Name of Physician______________________________ Phone: ______________

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician? Y N Please explain: ______________

Are you taking any prescription/over the counter drug(s)? Y N Please explain: ______________

Please list each one: ______________

Have you ever had any serious illness or operation? Y N Please explain:______________

DO YOU HAVE TO BE PREMEDICATED BEFORE DENTAL TREATMENT? Y N **HAVE YOU EVER TAKEN PHEN-FEN? Y N**

IF SO, HAVE YOU CONSULTED YOUR M.D. REGARDING HEART CONDITION. Please explain: ______________

FOR WOMEN

Are you taking birth control pills? Y N Are you pregnant? Y N Are you nursing? Y N

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	Heart Attack/Stroke	Y	N	High or Low Blood Pressure	Y	N	Ulcers
Y	N	Cancer/Chemotherapy	Y	N	Fever Blister	Y	N	Congenital Heart Defect
Y	N	Heart Murmur	Y	N	Severe/Frequent Headaches	Y	N	Radiation Treatment
Y	N	Rheumatic Fever	Y	N	Cardiac Pacemaker	Y	N	Asthma
Y	N	Heart Surgery/Pacemaker	Y	N	Psychiatric Problems	Y	N	Difficulty Breathing
Y	N	Shingles	Y	N	Epilepsy/Seizures/Fainting	Y	N	Hospitalized for any reason
Y	N	Mitral Valve Prolapse	Y	N	Diabetes	Y	N	Hepatitis
Y	N	Kidney Problems	Y	N	Drug/Alcohol Abuse	Y	N	Blood Transfusion
Y	N	Artificial Bones/Joints	Y	N	Venereal Disease	Y	N	Emphysema
Y	N	Artificial Valves	Y	N	Hemophilia/Abnormal Bleeding	Y	N	HIV+/AIDS
Y	N	Sinus Problems	Y	N	Glaucoma	Y	N	Anemia
Y	N	Tuberculosis (TB)	Y	N	Colitis	Y	N	Arthritis

Please list any medical condition(s) that you have ever had: ______________

Are you allergic to any of the following drugs or materials?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Codeine	Y	N	Antibiotics
Y	N	Sulfa Drugs	Y	N	Latex	Y	N	Other

Please list any other drugs that you are allergic to:______________

MEDICAL HISTORY

Previous Dentist______________________________ Phone: ______________

Dental Complaint at this moment? ______________

Have you ever had any unfavorable reaction from a local anesthetic? ______________

Have you ever had any serious trouble associated with any previous dental treatment? ______________

Explain: ______________

How long since last dental X-Rays of your entire mouth? ______________ How long since last dental treatment? ______________

Do you have or do you use any of the following?

Y	N	Bleeding gums	Y	N	Complications from extractions	Y	N	Water jet device
Y	N	Food impaction	Y	N	Periodontal (gums) treatment	Y	N	Fluoride supplements
Y	N	Clenching or grinding	Y	N	Orthodontic treatment	Y	N	Fluoride treatments
Y	N	Bad breath	Y	N	Cigarettes, pipe or cigar smoking			
Y	N	Unpleasant taste	Y	N	Dental floss			

CONSENT FOR TREATMENT: I hereby authorized to the dentist(s) in charge of the care of the patient whose name appears on this form to administer any treatment, or to administer such anesthetic, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such dental operations or procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed ______________________________ Date______________

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.