PATIENT REGISTRATION AND MEDICAL HISTORY

Date ______________________ Home Phone ______________________

Last Name ______________________ First Name ______________________ Initial ________

Preferred Name ____

Street Address ____

City ______________________ State __________ Zip__________

Sex: M ___ F ___ Age: __________ Birth date: ______________________

Single ___ Married ___ Widowed ___ Separated ___ Divorced ___

Employed by ______________________ Occupation ______________________

Business Address ______________________ Business Phone ______________________

Spouse/Parent Name ______________________ Spouse/Parent Birth date ______________________

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 ______________________ Group Number ______________________

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

Whom 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)

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

Do you have any drug allergies or have you ever had and 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 physican? Yes ______ No ______

For what conditions? ______________________

If patient is a child, what is his/her 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 ______________________

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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 of Insured/Guardian ______________________

Minor/Child Consent

I, being the parent or guardian of ______________________ do hereby request 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:

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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 Insured/Guardian ______________________________

Date ______________ Signature of Insured/Guardian ______________________________

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 Insured/Guardian ______________________________

Date ______________ Signature of Insured/Guardian ______________________________

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