

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____

(PLEASE PRINT)

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Alt. Phone (_____) _____ Email address: _____

Sex: M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Employed by _____ Occupation _____

Employer Address _____ Work Phone (_____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Employed by _____ Occupation _____

Employer Address _____ Work 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 (_____) _____

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):

- | | | |
|--|---|---|
| <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"/> HIV / AIDS or
Other Immunosuppressive Disorders |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Thyroid Disease |
| <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, please describe _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Are you under the care of a physician? 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 _____

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*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of Minor/Child
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*

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 *Patient Signature*

Date *Dentist Signature*

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 *Patient Signature*

Date *Dentist Signature*