PATIENT REGISTRATION AND HEALTH HISTORY

Patient Information

Patient Name: ____ Date: ________________________________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other:________________________

Social Security #: _________________________________ Birth Date:____

Address: ____
Street Apartment #

____
City State Zip Code

Phone (Home): ________________ (Work): ________________ Ext:______ (Cell): ___________________________

Email Address:___________________________________ Driver's License Number__________________State________

Employer Name and Address:____

Next of Kin to contact in case of emergency:____
Name Address Phone

Guarantor/Spouse Information

The following information is for: ☐ the person responsible for payment (Guarantor) ☐ the patient's spouse

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ___________________

Social Security #: _________________________________ Birth Date: ______________________________________

Phone (Home): ________________ (Work): ________________ Ext:______ (Cell): __________________________

Address (if different from above):____
Street Apartment #

____
City State Zip Code

Employer:___________________________________ Address:____

Primary Dental Insurance Information

Name of Subscriber: ____ Is Subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _________________ ID/SS #______________________ Group #:_____________________

Subscriber's Home Address: ____
Street City State Zip Code

Subscriber's Employer: ____ Phone:_________________________

Address: ____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____________________________________

Insurance Company: ____

Address and Phone:____
Street City State Zip Code Phone

Please advise the business office of any additional insurance coverage.

Dental History

Date of last dental visit:____________________

Are you happy with the appearance of your teeth? ☐ Yes ☐ No

Does dental treatment make you nervous? ☐ Yes ☐ No If Yes, ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever had a bad dental experience? ☐ Yes ☐ No

Previous periodontal treatment? ☐ Yes ☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:____

Referred by:______________________ ☐ Patient ☐ Doctor ☐ Phone Book ☐ Other________________________________

Health Information

Have you ever had any of the following? Please check those that apply:

□ AIDS/HIV	□ Cortisone Medicine	□ Heart Surgery	□ Psychiatric Treatment
□ Allergies (Seasonal)	□ Diabetes	□ Hepatitis	□ Radiation/Chemotherapy
□ Anemia	□ Drug/Alcohol Addiction	□ High Blood Pressure	□ Respiratory Problems
□ Angina	□ Emphysema	□ Jaundice	□ Rheumatic Fever
□ Artificial Joints:	□ Epilepsy	□ Kidney Disease	□ Sickle Cell Disease
__________________	□ Excessive Bleeding	□ Liver Disease	□ Sinus Problems
□ Arthritis	□ Fainting/Dizziness	□ Mental Disorders	□ Sleep Problems
□ Asthma	□ Glaucoma	□ Nervous Disorders	□ Stomach Problems/Ulcers
□ Blood Disease	□ Growths or Tumors	□ Osteoporosis	□ Stroke
□ Bruise Easily	□ Head Injuries	□ Pacemaker	□ Thyroid Disease
□ Cancer	□ Heart Disease	□ Pain in Jaw Joints	□ Tuberculosis
□ Codeine Allergy	□ Heart Murmur	□ Penicillin Allergy	□ Venereal Disease__________________
□ Cold Sores/Fever Blisters/Ulcers		□ **Pregnancy**	□ Other:____________________________
□ Cosmetic Surgery	□ Heart Valve	**Due Date**__________	_________________________________

Specifics on items checked above:____

□ Have taken or currently take Actonel, Boniva, Didronel, Fosamax, or Skelid.

□ Have taken or now take prescription diet drugs, including Phen Fen or Redux.

Name of Physician:____Phone:____

Current medications (including OTC, vitamins, herbal):____
____

Are you allergic to or had any adverse reaction to any medication or substance? □ Yes □ No ______________________________

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

Are you now under the care of a physician? □ Yes □ No If yes, please explain:____

Do you have any health problems that need further clarification? □ Yes □ No

If yes, please explain:____

Do you smoke or use tobacco products? □ Yes □ No If yes, how much?____

Do you have more than 7 alcoholic drinks (including beer and wine) in a week? □ Yes □ No

Do you have pain in your chest, shortness of breath, or get very tired when you walk up stairs or take a walk? □ Yes □ No

Do your ankles swell during the day? □ Yes □ No Do you ever wake up from sleep short of breath? □ Yes □ No

Do you snore? □ Yes □ No Do you use C Pap machine? □ Yes □ No

Have you gained or lost more than 10 lbs. during the past year? □ Yes □ No Are you on a special diet? □ Yes □ No

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date:____

Signature of patient, parent or guardian

Payment Agreement

I understand that responsibility for payment for services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other financial arrangements have been made. I understand that this office will prepare any insurance claim forms, will assist in making collections from insurance companies, and will credit such collections to my account. I authorize insurance benefits to be paid directly to the doctor. **I also understand that it is my responsibility to pay in full any balance due on an insurance claim over 75 days old**. I understand that a 1.5% service charge (18% per annum) will be added to unpaid balances exceeding 90 days. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
I have read the above conditions of treatment and payment and agree to their content.

____ Date: _____________ Relationship to Patient: __________________________

Signature of patient, parent or guardian