

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

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

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

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 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"/> "A.I.D.S." or Other
Immunosuppressive Disorders |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Allergies to Medicine or Drugs | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Arthritis | |

Do you have any drug allergies or have you ever had an 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 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 information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance or 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 committed in the completion of this form.

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. I hereby authorize payment of the dental benefits otherwise payable to me directly to this dental entity.

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/Guardian Signature Date Dentist Signature

This is to authorize our office to send the patient's x-rays to the Specialists as requested or referred.

Signature of Patient/Guardian _____

Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature of Insured/Guardian _____ Date: _____

Date

Dentist Signature