

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

ACCOUNT INFORMATION	
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>	
NAME	
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.
ADDRESS	
CITY	STATE ZIP
PHONE NO.	
<b>YOU</b>	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.
<b>YOUR SPOUSE</b>	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.

DATE			
LAST NAME		FIRST	M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
PHONE		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
DATE			
LAST NAME		FIRST	M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

IF YOUR CHILD'S LAST NAME/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE	
<b>PRIMARY CARRIER</b>	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
<b>SECONDARY CARRIER</b>	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

### CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital or any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

# MEDICAL HISTORY

Patient Name _____	
Patient Account No. _____	Medical Alert _____

1. Have you been under the care of a medical doctor during the past two years? .....Yes No  
 If yes, for what? \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
2. Have you taken any medication or drugs during the past two years? .....Yes No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin? .....Yes No
4. Are you aware of having an allergic (or **adverse**) reaction to any medication or substance? .....Yes No  
 If yes, please list: \_\_\_\_\_
5. Have you been a patient in the hospital during the past five years? .....Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.
 

Heart (Surgery, Disease, Attack) .....Yes No	Ulcers .....Yes No	Hepatitis A (infectious) B (serum) .....Yes No
Chest Pain .....Yes No	Diabetes .....Yes No	Venereal Disease .....Yes No
Congenital Heart Disease .....Yes No	Thyroid Problems .....Yes No	A.I.D.S. ....Yes No
Heart Murmur .....Yes No	Glaucoma .....Yes No	H.I.V. Positive .....Yes No
High Blood Pressure .....Yes No	Contact lenses .....Yes No	Cold Sore/Fever Blisters .....Yes No
Mitral Valve Prolapse .....Yes No	Emphysema .....Yes No	Blood Transfusion .....Yes No
Artificial Heart Valve .....Yes No	Chronic Cough .....Yes No	Hemophilia .....Yes No
Heart Pacemaker .....Yes No	Tuberculosis .....Yes No	Sickle Cell Disease .....Yes No
Rheumatic Fever .....Yes No	Asthma .....Yes No	Bruise Easily .....Yes No
Arthritis/Rheumatism .....Yes No	Hay Fever .....Yes No	Liver Disease .....Yes No
Cortisone Medicine .....Yes No	Latex Sensitivity .....Yes No	Yellow Jaundice .....Yes No
Swollen Ankles .....Yes No	Allergies or Hives .....Yes No	Neurological Disorders .....Yes No
Stroke .....Yes No	Sinus Trouble .....Yes No	Epilepsy or Seizures .....Yes No
Diet (Special/Restricted) .....Yes No	Radiation Therapy .....Yes No	Fainting or Dizzy Spells .....Yes No
Artificial Joints (hip, knee, etc.) .....Yes No	Chemotherapy .....Yes No	Nervous/Anxious .....Yes No
Kidney Trouble .....Yes No	Tumors .....Yes No	Psychiatric/Psychological Care .....Yes No
7. Do you use more than two pillows to sleep? .....Yes No
8. Have you lost or gained more than 10 pounds in the past year? .....Yes No
9. Do you have or have you had any disease, condition, or problem not listed? .....Yes No  
 If yes, please list: \_\_\_\_\_

10. **Women.** Are you: **Pregnant?** Yes, \_\_\_\_\_ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

History Review	
Dentist's Signature	Date