Welcome!

REGISTRATION FORM

Section I: **Patient Information** **Date______________**

Name:____ I Prefer to be called: ________________________
Address:____City:_______________State:_________Zip_______________
Phone (______)_________________ Work Phone (_____) _______________ Cell Phone (______)__________________
The best time to contact me is:_________________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_______________ Social Security Number:_________________________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School______________________________ City/State_____________________________ ☐ FT ☐ PT
Spouse or Parent's Name:______________________________ Employer__________________ Work Phone____________
Whom may we thank for referring you? ____
Person to contact in case of emergency_____________________________________ Phone_________________________
Email Address____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:____ Relationship to Patient: ______________________
Address:____
City:_________________________________ State:__________ Zip:_____________ Phone: (____)______________________
Employer_________________________ Work Phone (____)_________________ SSN#_______________________________

Section III **Insurance Information**

Name of Insured_________________________________DOB_______________Relationship to Patient ________________
SSN#:________________________ Name of Employer:_______________________ Work Phone: (____)_______________
Address of Employer:___________________________________City_________________State:________Zip ___________
Insurance Company_____________________________ Grp #______________________ ID#_________________________
Ins Co Address:____ Ins Co. Phone:_____________________________

------------ DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ------------

Name of Insured_________________________________DOB_______________Relationship to Patient ________________
SSN#:________________________ Name of Employer:_______________________ Work Phone: (____)_______________
Address of Employer:___________________________________City_________________State:________Zip ___________
Insurance Company_____________________________ Grp #______________________ ID#_________________________
Ins Co Address:____ Ins Co. Phone:_____________________________

MEDICAL AND DENTAL HISTORY FORM

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that benefits your overall health and well-being.

Within the past year, have there been any changes in your general health?

Yes ____ No ____

What is the date (or approximate date) of your last medical exam? ______________________________

Your Primary Care Physician's name and address: ____

Please mark any of the following to indicate YES in response to the question:

____ Have you ever taken pre-med prior to dental visits?

____ Are you currently under the care of a physician due to a specific condition?

____ Have you been hospitalized within the last 5 years due to a surgery or illness? Please specify.

____ Are you currently taking any prescription or non-prescription drugs? Please specify.

____ Do you use tobacco (smoking or chewing)?

____ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant or nursing?

Yes ____ No ____

Please indicate if you have experienced any of the following:

____ Allergies	____ Anemia	____ Arthritis
____ Artificial Joints	____ Asthma	____ Back Problems
____ Birth Control Pills	____ Blood Disease	____ Blood Thinner
____ Breast Implants	____ Cancer	____ Chemotherapy
____Codeine Allergy	____ Cough, Persistant	____ Diabetes
____ Dizziness	____ Epilepsy	____ Excessive Bleeding
____ Fainting	____ Glaucoma	____ Hay Fever
____ Head Injuries	____ Headaches, Migraines	____ Heart Murmur
____ Heart Problems	____ Hepatitis	____ High Blood Pressure
____ HIV/AIDS	____ Jaundice	____ JAW PAIN
____ Kidney Disease	____ LATEX Allergy	____ Liver Disease
____ Mental Disorders	____ Mitral Valve Prolapse	____ Nervous Disorder
____ Pacemaker	____ Penicillin Allergy	____ PRE-MED
____ Radiation Treatment	____ Respiratory Problems	____ Rheumatism
____ Seasonal Allergies	____ Siezures	____ Sinus Problems
____ Skin Rash	____ Stomach Problems	____ Stroke
____ Sulfur Allergy	____ Taking Medications	____ Thyroid Problems
____ Tobacco Habit	____ Tuberculosis	____ Tumors
____ Ulcers	____ Venereal Disease	

Do you have any other health issues or allergies?

What is the reasons for your dental visit today? ____

When was your last visit to the dentist (if to a different office)? _________________________________

Prior Dentist's name and address? ____

Please mark any of the following to indicate Yes in response to the question:

____ Do your gums bleed when you brush or floss?

____ Do your teeth experience sensitivity to cold or hot temperatures?

____ Are any of your teeth currently causing you pain?

____ Do you grind your teeth (either consciously or during sleep)?

____ Are any of your teeth loose?

____ Do you currently have any dental implants, dentures or partials?

If any of the previous questions are marked, please explain:

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examinations for myself and my dependent(s) to third-party insurance carriers, payors and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by my insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent or guardian:

Signature: ____ Date: _______________

Relationship to Patient: ____