

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____) _____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone (____) _____

Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Employer _____ Occupation _____

Employer Address _____ Employer Phone (____) _____

Spouse Name _____ Spouse Birthdate _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse 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"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Artificial Heart Valves or Joints, Screws, etc	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Bleeding Abnormally	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Special Diet
<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Stroke
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Swollen Neck Glands
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? Yes No

If so, what? _____

Have you ever responded adversely to medical or dental treatment? Yes No

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 Due date _____

Are you nursing? Yes No Taking birth control pills? Yes No

Is there anything else we should know about your medical history? _____

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has had a change in health.

MINOR/CHILD CONSENT

I am the parent/legal guardian or personal representative of _____
Print Name of Minor/Child

And there are no court orders that prohibit me from signing this consent. I here do authorize the dental staff to perform necessary dental services for the child/minor named above, including x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is covered by dental insurance with _____
Name of Insurance Company

and assign directly to Dr. _____ all insurance 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 authorize the use of my signature on all insurance submissions. The above named doctor may use my minor/child's health care information and may disclose such information to the above-mentioned Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This will end when the current treatment plan is completed or one year from the date signed below.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of services rendered/treatment, unless other arrangements are made. I am fully responsible for all fees and services rendered for treatment. I accept full financial responsibility for all charges for services provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. All insurance pre-determinations are not a guarantee of payment by the insurance.

Name of Patient/Parent/Guardian

Signature of Patient/Parent/Guardian

Date