

PATIENT REGISTRATION and MEDICAL / DENTAL HISTORY Date _____

Patient Name _____
(Last) (First) (Middle Initial) (Preferred to be called)

Address _____
(City) (State) (Zip)

Home Phone # _____ Cell Phone # _____ E-mail _____

Social Security # _____ Age _____ Birthday ____/____/____

Sex: Male Female Are You: Single Married Widowed Separated Divorced

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

Is the Patient covered under any insurance plans? No Yes = Please fill out the Insurance information below.

Dental Insurance Primary Carrier: _____
(Insured's Employer)

_____ Birthday ____/____/____
(Insured Name) (Social Security #)

_____ (Insurance Company) (Group Number) (ID Number)

Dental Insurance Secondary Carrier: _____
(Insured's Employer)

_____ Birthday ____/____/____
(Insured Name) (Social Security #)

_____ (Insurance Company) (Group Number) (ID Number)

Emergency Contact Person _____ Phone # _____

Whom may we thank for referring you? _____ Phone # _____

Who is your primary care Physician? _____ Last Physical _____

Allergies to Medications if so please list: _____

List all current medications: _____

Please check the box of any conditions that apply.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Respiratory Problem | <input type="checkbox"/> Cancer, Leukemia | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> A.I.D.S./ HIV Positive | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Arthritis/Rheumatism |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Allergy to Latex |
| <input type="checkbox"/> Hepatitis, Jaundice | <input type="checkbox"/> General Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headaches | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Birth Control |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Other Medical Conditions |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Allergies to Anesthetics | _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Psychiatric Care | _____ |

The above information is accurate and complete to the best of my knowledge I authorize the dentist to release any information, records of any treatment or examination rendered to the patient listed above, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Parent if minor _____ Date _____