PATIENT REGISTRATION

First Name: ________________________ Last Name: ________________________ Middle Initial: ____
Patient is: Policy Holder ☐ Responsible Party ☐ General Dentist: ________________________________

PATIENT INFORMATION

Home Address: ______________________________ Mailing Address: ______________________________
City: ______________________________ State/Zip: ______________________________
Home Phone: _______________ Cell Phone: _________________ Work Phone: ____________ Ext: ___
E-Mail: ____ Receives Text Messages: ☐ Receives E-mail: ☐

Birth Date: ______________ Soc. Sec.: ________________________ Sex: Male ☐ Female ☐

Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

RESPONSIBLE PARTY (If someone other than the patient)

First Name: ________________________ Last Name: ________________________ Middle Initial: ____
Home Address: ______________________________ Mailing Address: ______________________________
City: ______________________________ State/Zip: ______________________________
Home Phone: _______________ Cell Phone: _________________ Work Phone: ____________ Ext: ___
E-Mail: ____ Receives Text Messages: ☐ Receives E-mail: ☐

Birth Date: ______________ Soc. Sec.: _________________ Sex: Male ☐ Female ☐

Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

PRIMARY DENTAL INSURANCE INFORMATION

Name of Subscriber: ____________________ Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐
Subscriber SS# or ID: ____________________ Group # _____________ Subscriber Birth Date: _____________
Subscriber Employer: ____________________ Insurance Company: _________________________________

SECONDARY DENTAL INSURANCE INFORMATION

Name of Subscriber: ____________________ Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐
Subscriber SS# or ID: ____________________ Group # _____________Subscriber Birth Date: _____________
Subscriber Employer: ____________________ Insurance Company: _________________________________

FINANCIAL DISCLAIMER

We will gladly file insurance claims on your behalf, but the doctor cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Insurance reimbursement, coverage and benefits are a contract between you and your insurance carrier. YOU ARE RESPONSIBLE FOR THE PROMPT PAYMENT OF YOUR ACCOUNT regardless of any pending insurance claim or settlement. You will receive a statement each month for the outstanding balance of your account, even though you have an insurance claim pending. YOU ARE RESPONSIBLE FOR THE ENTIRE FEE regardless of any insurance claim, determination, maximum, or limitations on benefits, including our customary fee not paid by your insurance carrier. NOTICE: ALL ACCOUNTS NINETY (90) DAYS PAST DUE ARE SUBJECT TO A SERVICE CHARGE OF 1% A MONTH ON THE UNPAID BALANCE AND MAY BE FORWARDED TO A COLLECTION AGENCY.

I agree to be responsible for payment of my additional collection cost, and/or attorney fees and court costs to collect an unpaid account. By my signature, I understand the foregoing policy and assume the responsibility for prompt payment of services needed.

Signature: ____Date: ______________________________

HEALTH HISTORY

Patient Name ______________________________ Birth Date ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

MEDICAL HISTORY

Are you under a physician's care now? Yes No If yes, explain: ______________

Are you taking any medications, pills, or drugs? (if you have a list we will gladly copy it) Yes No If yes, explain: ______________

Have you ever taken Fosamax, Boniva, Actonel or any other medications for osteoporosis? Yes No If yes, explain: ______________

Are you taking blood thinners? Yes No If yes, explain: ______________

Do you need to Pre-Medicate prior to dental treatment? Yes No If yes, explain: ______________

What is your preferred pharmacy? ______________

Do you use recreational drugs? Yes No If yes, explain: ______________

Do you use tobacco? If yes, which form or how many packs per day? Yes No If yes, explain: ______________

Women: Are you Pregnant/trying to get pregnant? Yes No Nursing? Yes No

Are you allergic to any of the following? Please circle any that apply.

Aspirin	Penicillin	Codeine	Latex	Local Anesthetics
Sulfa Drugs	Morphine	Valium or Versed	Other	______________

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Heart Surgery	Yes	No	Alzheimer's Disease	Yes	No
Anaphylaxis	Yes	No	Hepatitis B or C	Yes	No	Tuberculosis	Yes	No
Herpes	Yes	No	High Blood Pressure	Yes	No	Epilepsy or Seizures	Yes	No
Excessive Bleeding	Yes	No	Artificial Joint	Yes	No	Fainting/Dizziness	Yes	No
Blood Disease	Yes	No	Cancer/Leukemia	Yes	No	Bruise Easily	Yes	No
Breathing Problems	Yes	No	Stroke	Yes	No	Sinus Trouble	Yes	No
Chest Pains/Angina	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Pain in Jaw Joints	Yes	No	Heart Pacemaker	Yes	No
Heart Trouble/Disease	Yes	No	Radiation/Chemotherapy	Yes	No	Dry Mouth	Yes	No
Diabetes	Yes	No	Renal Dialysis	Yes	No	Artificial Heart Valve	Yes	No
Ulcers	Yes	No	Blood Transfusion	Yes	No			

Is there any condition, disease or problem not listed above that should be noted? Yes No

If yes, explain: ______________

DENTAL HISTORY

Do your gums bleed? If yes, when? Yes No If yes, explain: ______________

Have you ever had a periodontal abscess? Yes No

Are your gums sore or swollen? Yes No

Are any of your teeth loose? Yes No

Have you ever had Scaling and Root Planing? If yes, when? Yes No If yes, explain: ______________

Have you ever had periodontal surgery? If yes, when? Yes No If yes, explain: ______________

Are your teeth sensitive? Yes No

When were your teeth last cleaned? How long before then? Comment: ______________

Do you have any other concerns regarding dental treatment? Comment: ______________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE ______________________________ DATE ______________