PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1

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.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

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

2

DENTAL INSURANCE	
PRIMARY CARRIER	
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.	
SECONDARY CARRIER	
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.	

3

GETTING TO KNOW YOU	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP:
YOU WERE REFERRED TO US BY	
YOUR FORMER ADDRESS	
CITY	STATE ZIP
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP

4

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

FORM 001-0301

Please turn over and sign

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 of 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 _____

PATIENT'S NAME _____
Last First Initial

CIRCLE THE APPROPRIATE ANSWER

1. Physician's Name _____
   ADDRESS _____
   _____
2. Are you under a physician's care? ..... YES NO
   Since When? _____ Why? _____
3. When was your last complete physical exam? _____
4. Height: _____ Weight: _____
5. Are You taking any medication? ..... YES NO
   If yes, please list medications: _____
6. Do you routinely take aspirin or other non-prescription medicines? ..... YES NO
   If yes, please list: _____
7. Are you allergic to any medications? ..... YES NO
   If yes, please list: _____
8. Do you have any other allergies? _____
9. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
10. Are you sensitive to any metals or latex? ..... YES NO
11. Are you pregnant or suspect you may be>? ..... YES NO
12. Do you use any birth control medications? ..... YES NO
13. Have you ever been treated for or told you might have a heart disease ..... YES NO
14. Do you have a pacemaker or an artificial heart implant? ..... YES NO
15. Have you ever had rheumatic fever? ..... YES NO
16. Are you aware of any heart murmurs? ..... YES NO
17. Do you have high or low blood pressure? ..... YES NO
18. Have you ever had a serious illness or major surgery? ..... YES NO
    If yes, explain _____
19. Have you ever and radiation treatment, chemo treatment for a tumor growth or other condition? ... YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
21. Do you have any artificial joints / prosthesis? ..... YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? ..... YES NO
23. Have you ever bled excessively after being cut or injured? ..... YES NO
24. Do you have any stomach problems? ..... YES NO
25. Do you have any kidney Problems? ..... YES NO
26. Do you have any liver problems? ..... YES NO
27. Are you diabetic? ..... YES NO
28. Do you have asthma? ..... YES NO
29. Do you have epilepsy or seizure disorders? ..... YES NO
30. Do you or have you had venereal disease? ..... YES NO
31. Have you tested HIV positive? ..... YES NO
32. Do you have AIDS? ..... YES NO
33. Have you had or do you test positive for hepatitis? ..... YES NO
34. Do you or have you had TB? ..... YES NO
35. Do you smoke, Chew, use snuff or any other forms of tobacco? ..... YES NO
36. Do you consume alcoholic beverages? ..... YES NO
37. Do you habitually use controlled substances? ..... YES NO
38. Have you had psychiatric treatment? ..... YES NO
39. Do you have any disease, condition or problem not listed? ..... YES NO
    If yes, explain: _____
40. Is there anything else we should know about your health that we have not covered in this form?
    _____
41. Would you like to speak to the Doctor privately about any problem? ..... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

[PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MEDICAL HISTORY

MED. ALERT