

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE
NAME
SPOUSE
ADDRESS
CITY STATE ZIP
HOME PHONE NO.
E-MAIL
BIRTHDATE SS#
MARRIED SINGLE DIVORCED WIDOWED
DATE
NAME
ADDRESS
CITY STATE ZIP
HOME PHONE NO.
BIRTHDATE AGE GRADE
SCHOOL
IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO.

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
EMPLOYER	
EMPLOYEE BIRTHDATE	
DATE EMPLOYED	
EMP. SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
EMPLOYER	
EMPLOYEE BIRTHDATE	
DATE EMPLOYED	
EMP. SOCIAL SECURITY NO.	

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

ACCOUNT INFORMATION	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
DRIVERS LICENSE NO.	
BANK	
BRANCH	
ACCOUNT NO.	
YOUR:	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS CITY	
BUSINESS TELEPHONE EXT.	
YOUR SPOUSE:	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS CITY	
BUSINESS TELEPHONE EXT.	

FOR INSURANCE ASSIGNMENT

I AUTHORIZE RELEASE ON ANY INFORMATION RELATING TO THIS OR FUTURE DENTAL CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? YES NO
2. Do you feel very nervous about having dental treatment? YES NO
3. Have you been a patient in the hospital during the past two years? YES NO
4. Have you been under the care of a physician during the past two years? YES NO
Physician's Name _____
Address _____ Phone # _____
5. Have you taken any medicine or drugs during the past two years? YES NO
Are you now taking any medicine, drugs or pills? YES NO
If yes, please list: _____
6. Are you aware of being allergic to any medications or substance?
If yes, please list: _____

7. Circle any previous or present condition:

- | | | |
|---|--|----------------------------------|
| A. AIDS | I. Heart Problem | P. Rheumatic Fever |
| B. Arthritis | J. Hepatitis | Q. Sexually Transmitted Diseases |
| C. Asthma | K. High Blood Pressure | R. Stroke |
| D. Cancer | L. Jaundice | S. Tuberculosis |
| E. Diabetes | M. Kidney Problems | T. Other Diseases |
| F. Epilepsy | N. Low Blood Pressure | |
| G. Glaucoma | O. Nervous Breakdown
or Psychiatric Therapy | |
| H. Heart Murmur or
Mitral Valve Prolapse | | |

If you circled either I or T describe condition: _____ _____
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8. Has your medical doctor ever told you, you have a cancer or a tumor? YES NO
9. Have you ever had a skin rash or other reaction to metal jewelry? To what? _____ YES NO
10. Have you ever been involved with dental/medical legal activity? YES NO

FOR WOMEN ONLY:

Are you pregnant? Yes No If yes, what month? _____ Are you taking birth control pills? Yes No

THE ABOVE INFORMATION IS TRUE

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Patient Signature _____ Date ____/____/____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____