PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1

DATE

NAME

SPOUSE

ADDRESS

CITY STATE ZIP

HOME PHONE #

BIRTHDATE AGE

MARRIED SINGLE DIVORCED WIDOWED

CELL PHONE #

E-MAIL

NAME

ADDRESS

CITY STATE ZIP

HOME PHONE #

BIRTHDATE AGE

SCHOOL

IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO

DENTAL INSURANCE 2

PRIMARY CARRIER

INSURANCE CARRIER

EMPLOYEE

UNION OR LOCAL #

GROUP #

EMP. BADGE #

DATE EMPLOYED

EMP. SOCIAL SECURITY #

SECONDARY CARRIER

INSURANCE COMPANY

EMPLOYEE

UNION OR LOCAL #

GROUP #

EMP. BADGE #

DATE EMPLOYED

EMP. SOCIAL SECURITY #

GETTING TO KNOW YOU 3

IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT AT OUR OFFICE? THEIR NAME:

REFERRED TO US BY:

FORMER ADDRESS

CITY STATE ZIP

PERSON TO CONTACT FOR EMERGENCY - NOT HOME #

PHONE #

ADDRESS

CITY STATE ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE #

ADDRESS

CITY STATE ZIP

ACCOUNT INFORMATION 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

DRIVERS LICENSE #

BANK / ACCT. #

PAYMENT METHOD

CASH CHECK CREDIT

YOUR INFORMATION

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS CITY

BUSINESS TELEPHONE EXT.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS CITY

BUSINESS TELEPHONE EXT.

HEALTH HISTORY

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 ever had a bad experience in a dental office? .... YES NO
4. Have you been a patient in a hospital during the past two years? .... YES NO
5. Have you been in the care of a medical doctor during the past two years? .... YES NO

   Physician's Name________________________________

   Address________________________ Phone #________________

6. Have you taken any medicine or drugs during the past two years? .... YES NO
7. Are you now taking any medication, drugs or pills? .... YES NO

   If so, please list________________________________

8. Are you allergic or have you reacted adversely to any of the following medications? ....

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Codeine	Erythromycin	Demerol	(Novocaine or Xylocaine)
Tetracycline	Penicillin	Other Antibiotics	Sleeping Pills

9. Are you aware of being allergic to any other medications or substance? .... YES NO

   If so, please list________________________________

10. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS / HIV+
Heart Disease or Attack	Cough/Tuberculosis (TB)	Hepatitis A (Infectious)
Angina Pectoris	Asthma	Hepatitis C (Infectious)
High Blood Pressure	Hay Fever / Sinus Trouble	Liver Disease
Heart Murmur	Allergies or Hives	Blood Transfusion
Rhuematic Fever	Diabetes	Alcohol / Drug Abuse
Congenital Heart Lesions	Thyroid Disease	Hemophilia / Abnormal Bleeding
Scarlet Fever	Radiation	Venereal Disease (Syphillis, Gonorrhea)
Artificial Heart Valve	Chemotherapy (Cancer, Leukemia)	Cold Sores / Fever Blisters
Heart Pacemaker	Arthrits / Rheumatism	Epilepsy or Seizures
Heart Surgery	Cortisone Medicine	Fainting or Spells
Artificial Joints (Hip, Knee)	Glaucoma	Nervousness / Psychiatric Treatment
Stroke	Pain in Jaw Joints	Ulcers
Kidney Trouble	Bruise Easily	Sickle Cell Disease

FOR WOMEN ONLY

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

ABOVE INFORMATION IS TRUE

Patient's 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 be 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 analgesic agents embodies a centain 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 a 1 1/2 % 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____/____/____

Parent or Responsible Party________________________ Relationship to Patient________________

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have seen "Notice of Privacy Practices" I understand that I may ask questions about this at any time.

Patient________________________________ Date____/____/____

Parent or Responsible Party________________________ Relationship to Patient________________