PATIENT REGISTRATION FORM

Welcome to our practice. We look forward to being partners in a lifetime of dental care.
Please take a moment to complete the information listed on this registration.

PATIENT INFORMATION

Patient Name _____ _____
LAST FIRST INITIAL check if child

Male _____ Female____ Birth date _____/____/_____ Soc. Sec. #_____-_____-_____

Address _____

City Preferred Contact Method - call home # _____call cell / send text to _____

_____ State _____ Zip _____

E-mail _____ (used only for contact info)

Whom may we thank for referring you? _____

In case of emergency, call _____

Contact information is used to confirm appointments. Our policy requires a verbal response to confirmation calls. Thank you for understanding this policy.
Please allow 24 hour notice for cancellation of appointment. Failure to adhere to this may result in a charge to your account.

PRIMARY INSURANCE (if applicable)

Insured Name_____ Birth date ____/____/_____Relation to patient _____

Subscriber Address (if different from patient) _____

Employer _____ Insurance Co _____

Phone # _____ Group #_____ Unique ID (or Soc Sec #) _____

ADDITIONAL INSURANCE (if applicable)

Is patient covered by additional insurance? _____

Insured Name _____ Birth date ____/____/_____Relation to patient _____

Address (if different from patient) _____

Employer _____ Insurance Co _____

Phone _____ Group #_____Unique ID (or Soc Sec #) _____

DENTAL HISTORY (for new patients)

Are you having dental discomfort today? _____ for how long?_____

H/C sensitivity ____ Pain /Throbbing ____ Sensitive to sweets ____ Dull ache_____

Chipped/lost Filling _____ Lost/Loose Crown _____ Clenching/Grinding Teeth _____

Bleeding Gums / Bad Breath _____ Fear about dental experiences _____

Date of last dental care _____ Date of last x-rays _____

Former Dentist Name _____Location _____ Phone _____

MEDICAL HISTORY

Physician's name _____ Location _____ Phone _____

Date of last visit _____Have you had any serious illnesses or operations **Y** or **N** (circle)

If yes, please describe _____

Are you currently under physician care? **Y** or **N** (circle) Women: Are you pregnant **Y** or **N** (circle)

Have you ever taken bisphosphonate (bone building) prescription drugs (Actonel, Boniva, Zometa, etc). **Y** or **N** (circle) If Yes, please list reason for medication and dosage, length of treatment

_____

_____

Please circle **Yes** or **No** whether you have had any of the following conditions, illnesses.

Y/N	AIDS/HIV positive	Y/N	Circulatory problems	Y/N	Heart surgery	Y/N	Pacemaker
Y/N	Anemia	Y/N	Cortisone treatments	Y/N	Hepatitis	Y/N	Sudden weight change
Y/N	Artificial heart valve	Y/N	Diabetes	Y/N	High Blood Pressure	Y/N	Radiation
Y/N	Artificial joints	Y/N	Epilepsy	Y/N	Jaw Pain	Y/N	Respiratory disease
Y/N	Asthma	Y/N	Fainting	Y/N	Kidney disease	Y/N	Shortness of breath
Y/N	Allergy prone	Y/N	Food allergies	Y/N	Liver disease	Y/N	Stroke
Y/N	Blood disease	Y/N	Headaches	Y/N	Material allergies	Y/N	Surgical implant
Y/N	Cancer	Y/N	Heart Murmur	Y/N	Mitral Valve prolapse	Y/N	Tobacco habit
Y/N	Chemical dependency	Y/N	Heart Problems	Y/N	Nervous problems	Y/N	Tuberculosis
Y/N	Chemotherapy	Y/N	Hemophilia/ abnormal bleeding				

Are you currently taking any medications, please list:_____

_____

_____

Do you have any drug allergies, please list _____

_____

AUTHORIZATION

☑ I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

☑ I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions.

☑ I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am responsible for all charges whether or not paid by insurance and I agree to pay such fees in full. If the bill is not paid in full, I, my spouse or responsible party will be liable for the cost of collections, including court costs, attorney fees and any finance charges.

Signature _____ **Date** _____
(parent or guardian if minor)

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT,
UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.