



PATIENT REGISTRATION FORM

Date: _____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____

If you would like appt. reminders at this #

Date of Birth (MO/DAY/YR) ____/____/____ Age: _____ Sex: Male Female

Soc. Sec.# ____ - ____ - ____ Driver's License # and State: _____

Place of Employment: _____ Occupation: _____

Business Address: _____

Business Phone: () _____ E-Mail Address: _____

Spouse/Parent/Guardian Name: _____

Address (if different): _____

In Case of Emergency Call: _____ Phone: () _____

Person Responsible for Payment: _____ Relationship: _____

Street Address (if different): _____

City: _____ State: _____ Zip: _____

Soc. Sec. #: ____ - ____ - ____ Driver's License # and State: _____

Place of Employment: _____ Occupation: _____

Business Address: _____ Business Phone: () _____

Primary Insurance:

Secondary Insurance:

Policy Holder: _____

Policy Holder: _____

Dental Insurance Co.: _____

Dental Insurance Co.: _____

Employer: _____

Employer: _____

Group #: _____

Group #: _____

Insured's Birth Date: _____

Insured's Birth Date: _____

Insured's Soc. Sec. #: ____ - ____ - ____

Insured's Soc. Sec. #: ____ - ____ - ____

Consent: The undersigned hereby authorizes Doctor to take radiographs, study models, photographs or any diagnostic aid 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, use medication and further authorize that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic, palliative and antibiotic agent embodies a certain risk.

Signature _____

Date _____

Agreement to Pay:

I agree to pay for all services rendered. In the event that the payment is not made within thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the agreed upon fee schedule.

Signature _____

Date _____

24-Hour Cancellation Notice:

There will be \$50.00 assessment for appointments not cancelled 24 hours before appointment time.

Signature _____

Date _____



MEDICAL HISTORY

Patient Name: _____ Date: _____ BP _____ PULSE _____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking Oral Contraceptives?

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Others _____

Do you have or have you had any of the following? Please circle Y for yes or N for no.

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

- | | |
|--|--|
| Y N Heart Disease | Y N Jaundice |
| Y N Heart Murmur/ Mitral Valve Prolapse | Y N Hepatitis Type _____ |
| Y N Stroke | Y N Diabetes |
| Y N Congenital Heart Lesions | Y N Excessive Urination and/or Thirst |
| Y N Rheumatic Fever | Y N Infectious Mononucleosis ("Mono") |
| Y N Abnormal Blood Pressure | Y N Herpes |
| Y N Anemia | Y N Arthritis |
| Y N Prolonged Bleeding Disorder | Y N Sexually Transmitted/Venereal Disease |
| Y N Tuberculosis or Lung Disease | Y N Kidney Disease |
| Y N Asthma | Y N Tumor or Malignancy |
| Y N Hay Fever | Y N Cancer/ Chemotherapy |
| Y N Sinus Trouble | Y N Radiation Therapy |
| Y N Epilepsy/Seizures | Y N History of Drugs/Addiction |
| Y N Ulcers | Y N AIDS |
| Y N Liver Disease | Y N Immune Suppressed Disorders |
| Y N Hearing Loss | Y N Fainting Spells |
| Y N Glaucoma | Y N History of Emotional or Nervous Disorders |
| Y N Artificial Joint _____ | |

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.

Please list all medications you are currently taking:

Physician's Name _____
Phone _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

DOCTOR'S SIGNATURE DATE

STOP **6 Month Update:** _____ **BP:** _____ **Pulse:** _____
Changes in Medication: _____

Changes in Health Status: _____

The information listed above is an accurate statement of my current health status.

Patient Signature Date Doctor/Hygienist Date

STOP **Year Update:** _____ **BP:** _____ **Pulse:** _____
Changes in Medication: _____

Changes in Health Status: _____

The information listed above is an accurate statement of my current health status.

Patient Signature Date Doctor/Hygienist Date