**PATIENT REGISTRATION AND MEDICAL HISTORY**

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last name First name Middle name

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Sex: Male Female Age\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_ Social security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Single Married

Who is responsible for this account? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s social security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Dental Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_ **Have you ever had any of the following?**

|  |  |  |
| --- | --- | --- |
| Heart problems | Epilepsy | Arthritis |
| High blood pressure | Headaches | Back problems |
| Low blood pressure | Hepatitis, Jaundice or Cancer | Liver disease |
| Circulatory problems | Chemical dependency | Respiratory disease |
| Nervous problems | Psychiatric care | Special diet |
| Radiation treatment | Chronic diarrhea | Rheumatic fever |
| Artificial heart valves or joints | Allergies to anesthetics | Sinus problems |
| Recent weight loss | Allergies to medicines | Diabetes |
| Venereal disease | General allergies | Strokes |
| Hemophilia | Blood disease | Ulcer |
| A.I.D.S or other Immunosuppressive Disorders | |  |

Do you have any drug allergies, or have you ever had an adverse reaction to any medication? \_\_\_\_ If so, what\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever responded adversely to medical or dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medication at this time? \_\_\_\_\_\_\_\_ If so, what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a physician? Yes No

For what conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is a child, what is his/her weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Women) Do you suspect that you are pregnant? Yes No Are you nursing? Yes No

Is there anything else we should know about your medical history? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**FINANCIAL AGREEMENT AND AUTHORIZATION**

I authorize my insurance company to pay to the dentist or dental group all insurance benefits

otherwise payable to me, for services rendered. I authorize the use of this signature on all insurance

submissions. I authorize the dentist to release all information to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by the insurance.

Any outstanding balance over 30 days is subject to an 18% annual interest or 1.5% monthly rate.

Payment is due in full at time of treatment unless prior arrangements have been approved.

The undersigned agrees, whether she/he signs as parent, spouse, guarantor, or patient, that in

consideration of the service to be rendered to the patient, he/she hereby individually obligates

himself/herself to pay the account. Should the account be referred to an attorney for collections,

the undersigned shall pay reasonable attorney’s fees, collection expenses and court costs.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name

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Date Patient’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Parent/Spouse/Guarantor Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number

Form of Payment:

Cash

MasterCard

Visa

American Express

Care Credit