PATIENT REGISTRATION

Today's Date _____

Name _____ Please circle one: Mr. Mrs. Ms. Dr. Child
Last First Middle

Address _____
Number & Street Apt# City State Zip

E-MAIL Address _____

Home Phone ( )_____ Work Phone ( )_____EXT _____ Cell Phone ( )_____

During the day, which number can you be reached? Home Work Cell

Date of Birth _____ _Sex _____ Age_____ Social Security Number _____ Marital Status _____

Employer _____ Address_____ Occupation_____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ ID#/SSN#_____

Address (if different from patient's) _____ Home Phone ( )_____

City _____ State _____ Zip _____

Business Address _____ Business Phone ( )_____

INSURANCE INFORMATION

Name of Insured _____ Employed by _____

Employers Address _____ City _____ State _____ Zip _____

Insurance Company _____

Address _____ City _____ State _____ Zip_____

Telephone # ( ) _____

Group# _____ Subscriber ID# _____

DENTAL INFORMATION

Circle any of the following that have occurred in your mouth or on your tongue, lips, neck, or body:

New swelling in mouth	Swollen purplish gums	Cold sores	Swollen glands
Bleeding gums	Canker sores	Broken / painful teeth	Rash / growth on cheek or tongue

Have you had unusual bleeding with precious extractions or surgery? Yes No

Last Dental Visit _____ Last Dental Cleaning _____ Last Dental X-rays_____

Continue on back

PATIENT REGISTRATION

MEDICAL INFORMATION

Are you currently under the care of a physician? Yes No

If so, what for? _____

Have you been a patient in the hospital in the last three years? Yes No

If so, what for? _____

Do you take recreational drugs? Yes No

If yes, how often? _____

List all medications you are currently taking, including over the counter drugs _____

_____

_____

Are you allergic to any medications? Yes No

If so, please list _____

Are you allergic to latex gloves? Yes No

Do you require antibiotic pre-medication before dental treatment due to a Heart Murmur or Mitral Valve Prolapse? Yes No

If female, are you pregnant now? Yes No

Please circle any of the following if you have had or now have:

Aids	HIV	Shortness of Breath	Jaundice	Hepatitis	Congenital Heart Lesion
Asthma	Allergies	Joint Replacement	Swollen Ankles	Kidney Problems	High Blood Pressure
Diabetes	Cancer	Anemia	Sinus Trouble	Venereal Disease	Organ Transplant
Herpes	Epilepsy	Pace Maker	Arthritis	Tuberculosis	Mitral Valve Prolapse
Stroke	HTLV III Virus	Heart Murmur	Chronic Cough	Artificial Heart Valve	Psychiatric Treatment

Other _____

_____

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. In the event payments are not received by agreed upon date, I understand that a 1.5% finance charge (18% APR) may be added to my account. If I have insurance, my signature below will serve as signature on file for electronic claim submission.

At this time I have received a copy of this office's Notice of Privacy Practices.

Patient _____ Date _____ Witness _____

Patient or Responsible Party _____ Relationship to Patient _____