DR. SANDRA D. DANIELS D.D.S.
PATIENT REGISTRATION AND MEDICAL HISTORY

Date:__ /___ /___ **Email Address** _____@_____

Patient _____
Last Name First Name Middle Initial

Home Phone ( ) ____-_____ **Work Phone** ( ) ____-_____ **Cell Phone** ( )____-____

_____ _____ _____ _____
Street address **City** **State** **Zip**

Sex: __M __ F **Birthday** ___ / ___ / _____ **Status**: ___Married ___ Single ___ Minor

Employer / School _____ **Occupation:** _____

Spouse's Name: _____**Birthday** :___ / ___ / ___ **Phone #** ( )____-_____

In case of Emergency, contact (specify someone who does not live in your household) Name:_____tel.#____-_____

DENTAL INSURANCE

Primary insurance

Name of the Subscriber: _____Birthday: ___ / ___/ ___ SSN of the Subscriber: ____ - ____- _____

Group #: _____Name of the insurance company: _____relationship to patient_____

Secondary Insurance

Name of the Subscriber: _____Birthday: ___ / ___/ ___ SSN of the Subscriber: ____ - ____- _____

Group #: _____Name of the insurance company: _____relationship to patient_____

Assignment and release

I certify that I, and/or my dependents(s) have insurance coverage with _____
Name of ins.comp.

And assign directly to **Dr. Sandra Daniels** all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed bellow.

_____ _____
Signature of patient, Parent, guardian or personal rep. Please print name of patient, parent, guardian or personal rep.

___/___/___ _____
Date Relationship to patient

DENTAL HISTORY

Reason for today's visit_____ Former Dentist _____City/state _____

Date of last dental visit ___/___/___ Date of last dental x-rays___/___/___

Please circle to indicate if you have any of the following**: BAD BREATH / BLEEDING GUMS / SENSITIVITY TO HOT OR COLD DRY MOUTH / LOOSE OR BROKEN FILLINGS / GUMS SWALLEN OR TENDER / JAW PAIN / PERIODONTAL TX / GRINDING TEETH / SORES IN YOUR MOUTH / MOUTH PAIN /**
HOW OFTEN DO YOU FLOSS? _____ AND BRUSH? _____

Name: Date:

HEALTH HISTORY

Physician's Name _____ Phone # ____-_____

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

AIDS/HIV – ANEMIA - ARTHRITIS - ARTIFICIAL HEART VALVES - ARTIFICIAL JOINTS - ASTHMA – BACK PROBLEMS - BLEEDING ABNORMALLY WITH EXTRACTIONS OR SURGERIES - BLOOD DISEASE - CANCER - CHEMICAL DEPENDENCY - CHEMOTHERAPY-CIRCULATORY PROBLEMS - HEART SURGERY - DIABETES - EMPHYSEMA - EPILEPSY - FAINTING - DIZZINESS - GLAUCOMA - HEADACHES - HEART MURMUR - HEART PROBLEMS - HEPATITIS _____ - HERPES - HIGH BLOOD PRESSURE – JAW PAIN - KIDNEY DISEASE - LOW BLOOD P. - MITRAL VALVE PROLAPSE - NERVOUS PROBLEM – PACEMAKER - PSYCHIATRIC CARE - RADIATION TREATMENT – RESPIRATORY DISEASE - RHEUMATIC FEVER - SCARLET FEVER - SHORTNESS OF BREATH - SINUS TROUBLE - SPECIAL DIET - SKIN RASH - STROKE - SWOLLEN FEET ANKLES OR NECK GLANDS -THYROID PROBLEMS TONSILLITIS - TUBERCULOSIS - TUMOR ON HEAD OR NECK - VENEREAL DISEASE - PREGNANT HIGH CHOLESTEROL OTHER:_____

ALLERGIES

___ASPIRIN ___ BARBITUTATES ___CODEINE ___ IODINE ___ LATEX ___ LOCAL ANESTHETIC ___PENICILLIN ___SULFA ___ OTHER

MEDICATION Please list any medications you are currently:

_____

_____

OFFICE POLICY AND FINANCIAL AGREEMENT.- If you are unable to keep an appointment, we ask that you kindly provide us with at least 48 Hours notice. This courtesy on your part will make it possible to give your appointment to another patient. Patients will be billed for late cancellations and or no-shows. Please schedule only definitive appointments. Same day or next day appointments will be given, based upon availability. We are closed on Fridays weekends and major holidays. As every effort is made to be on time for our patients, we ask that you extend the same courtesy to us by arriving a few minutes before your scheduled appointment. Co-payments and co-insurances are due at the time services are rendered. Forms of payment accepted by the office are check, Debit Card, Visa and MasterCard Credit Cards.

I,_____FULLY UNDERSTAND DR DANIELS' OFFICE POLICIES AND FINANCIAL AGREEMENT. Signature of yourself or parent, Guardian or personal representative _____ Date ___/___/____